Tackling Health Care Costs: Finding Common Ground
Alliance for Health Reform
The Commonwealth Fund
December 13, 2013

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MARILYN SERAFINI: Good afternoon, if we could get everybody to take a seat please, we will go ahead and get started. I'm Marilyn Serafini with the Alliance for Health Reform, on behalf of Jay Rockefeller, Roy Blunt and our Board of Directors; I would like to welcome everybody to today's program on healthcare costs and emerging areas of consensus. I would like to thank our partners in this endeavor, the Commonwealth Fund. They have done a lot of work in this area. While the growth of healthcare spending has moderated over the last few years, experts assure us that this is not the time to declare a victory. US spending on healthcare still exceeds spending in other countries, both in terms of percentage of GDP and also per capita spending.

It is also worth noting that Medicare consumed 15% of the federal budget in 2012 and in 2011, the first of the Baby Boomers hit the Medicare program. Medicare spending is projected to double by 2022. So while we typically talk about differences in this town, today we are going t be talking about areas of consensus and in particular, healthcare costs consensus. There have been a number of major proposals in the area of healthcare costs recently and the Commonwealth Fund has done some work in analyzing those proposals and finding common ground.

We are pleased to have Commonwealth as our partner today and also pleased to have Rachel Nuzum as co moderator today. Rachel is Vice President for federal and state health policy. Rachel is going to set the stage for us by framing areas of consensus identified by Commonwealth on cost containment proposals. Rachel?

RACHEL NUZUM: Thank you so much, Marilyn and thank you to the Alliance for Health Reform, thanks to you brave enough to join us on Friday the 13th to talk about healthcare costs. So hopefully this is not too frightening. As Marilyn said, we all understand the imperative that is facing policy makers at both the federal and the state level as well as employers, households and individuals. Healthcare costs are up to about three trillion dollars in 2012 in terms of national health expenditures and they are expected to rise to five trillion by 2022. And just for some context, that is roughly 20% of our GDP spent on healthcare and as Marilyn mentioned, the rate of healthcare cost growth, the rate of growth of the national health expenditures is starting to slow, but it is still unclear as to whether or not that is going to continue and what really is potentially driving those reductions. Regardless, controlling the costs has been a front and center policy issue for policy makers at the federal and state level where – and especially at the state level where balanced budgets are required and it's in addition families, employers and individuals.

Given the policy focus on controlling the healthcare cost growth as well as the belief that 2013 really offered an unprecedented opportunity to arrive at some policy resolutions, a number of stakeholder groups released a set of comprehensive proposals to control costs while improving the value we receive for our healthcare investment. Several of these groups included members and stakeholders, expanded the political continuum and while there were different approaches among the proposals, there was also an incredible

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amount of agreement among them and I think its – it would be wise not to underestimate the importance of the fact that all of these stakeholders and all of these groups were coming forward with comprehensive proposals at the same time. That alone sends a really important message that stakeholders across the political continuum agreed that much needs to be done to both control costs and to reform the health delivery system.

So it was the hope of the Commonwealth Fund to be able to shine a light on these areas of commonality, help to distinguish the difference in approaches and serve as tool for the policy making process. And there is a piece in your folder that gives you a link to the online tool that was developed out of this partnership. The partnership was with the George Washington University Department of Health Policy, Katy Horton and her team looked at reports from seven organizations and again, these were organizations that released comprehensive proposals – so not just a Medicare proposal or not just a coverage proposal, but a comprehensive proposal focusing on controlling healthcare costs through health system transformation.

So after careful analysis, the examination revealed substantial agreement on areas where action is needed. And as I mentioned before, even when the reports differ on specific recommendations, there were enough – there was enough commonality to suggest momentum in four key areas. And you see those here on the slide. Paying for value, moving to a system that pays for value over volume, looking at quality improvement in patient engagement, improving market competition and the setting of spending target – something that has been pretty controversial and I think that many of us were pretty surprised to see that in almost all of the proposals.

Considerable agreement when we look at the paying for value not for volume, there is many similarities to what is pending on the [unintelligible] bipartisan SUR proposals right now as well. So that really was part of the goal, was to see if some of this consensus could make its way into the policy making system. So you see here just some of the common elements of the proposals again, there is more information in your folder. All of them recommending moving away from current SGR formulas. All of them proposing to build upon or expand alternative delivery models and payment models such a primary care medical homes or accountable care organizations. And a lot of agreement on the importance of using the new health insurance marketplaces to encourage insurance practices that support a value based insurance design or value based purchasing.

On the quality improvement side, I think that some of the areas where we saw the most consensus was this idea around the need for core measures and core metrics and alignment between public and private programs and the measures that they use in order to make things a little bit more consistent and seamless for providers. Again, lots of differences in how on the proposal suggest we get to those goals, but much agreement on the need for core measures and there are some efforts underway at the IOM and with others to move in that direction.

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On the improving market competition, I think the area where we saw the most – the strongest areas of consensus were on the idea of price transparency. We had a lot of discussion over that in the last year and again, on differences in the way that the reports approach it, but an issue that we are hearing on both sides of the aisle in terms of the importance of shining some light on the cost of care and the prices paid.

And finally, setting spending targets. All of the proposals recommend spending targets. Some are at the programmatic level, some are at the more global level and all of the proposals really emphasize and encourage state level innovation. This just gives you a quick glance at the online tool that we have available. The online tool also does link to all of the individual proposals, so we really encourage you to take a look at this, to do some comparing and contrasting, and then to read more about the individual proposals. So with that, I just want to again, acknowledge our partners at GW, Katy Horton and her team and thank you for her work on this, as well as all of the organizations that Katy's team worked with. They did an extensive amount of analysis and interviews with those groups to make sure that we were really reflecting those proposals accurately. So thanks to all of the organizations that participated. Marilyn?

MARILYN SERAFINI: Great, thank you Rachel. Let me just go through a couple of logistical points before we get to the rest of the program. First, you will notice on the screen behind me, if you are interested in tweeting while we go through our program, you can follow – the hashtag is costconsensus. You can also use the hashtag if you would like to ask a question. If you would like to pose a question to our speakers and you are not in the room, you can send a question via Twitter. If you simply use the hashtag costconsensus, we will pick that up and pose the question to our speakers when the time comes. You can also send us a direct message on Twitter at @allhealthreform and we will also pick up your message that way. Of course you can – if you are in the room, you can ask a question when the time comes in one of two ways. We have microphones in the room or you can also use the green card in your packet to write a question and we will get the question to our speakers. You also picked up a packet in your way in and that packet has lots of great material for you. It has the full speaker biographies, it also has the Power Point presentations for those speakers who Power Points today. It also – we also have additional background material available for you at our website, www.allhealth.org. This is – this briefing is live on C-Span today, we also are – there will be a video on our website by Monday and that will be followed shortly after that by a transcript. One more point, in the packets you also have an evaluation form before you leave today, if you will be so good as to fill that out, we would be grateful.

So, now let's move on to the rest of our program and we are going to start – we are going to hear first from Paul Ginsburg who is the President of the Center for Studying Health System Change. Paul is a healthcare economist who has made it his group's business to know the trends in healthcare delivery across the country. Paul has been analyzing cost containment proposals; we have asked him to discuss areas of consensus, the likelihood

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of moving forward given the political atmosphere and also to look at just how concrete these proposals are in their ability to move us forward. Paul?

PAUL GINSBURG: Thank you Marilyn. That was Rachel that said, there is a lot of activity in developing comprehensive strategies for cost containment during this year. Many of them were motivated by the expectation that there would be substantial budget legislation and that would be an opportunity to put many of these ideas forward. Most of these entities were really seeking consensus and some of them had different stakeholders involved in the process, some had conservative and liberal policy experts, some had Republicans and Democrats and one was from the perspective of states. And I just want to mention that Sheila and I served as advisors to the bi-partisan policy center project that was released in April. The Robert Wood Johnson Foundation asked me to synthesize a lot of these reports and they had funded seven of the initiatives and I also added three others, one of which was the Commonwealth Funds reports and this is really about my synthesis. The consistency and vision across the reports was really striking. And I would use different words from Rachel – the consistence, which is diminishing the role of fee for service payments in medical care and using other payment approaches to promote coordination of care, management of populations and clinical integration. And they were seeking improved patient outcomes as well as cost reduction. And the goal is to achieve most of this transition by the end of this decade. So a pretty aggressive plan.

What were the strategies? In most of the reports, Medicare payment policy is a key lever in pushing the system forward. There was one report I mentioned about – it was called a state healthcare cost containment commission, which clearly was focusing on Medicaid policy as the key lever and that is parallel. Definitely a movement away from traditional policies of just cutting payment rates. These reports mentioned the limits of cost shifting, although some of them did identify some services that they thought the prices were too high, they were being paid by Medicare and called especially for a bidding processes to set lower prices. They all recognized the large savings for Medicare are achievable only through delivery system improvements that affect all of medical care. So the days of just squeezing Medicare rates and getting a lot of savings, according to these reports, we need to move past that.

Most of these reports had system wide policies as well. They included liability reform, role of nurse practitioners, the tax treatment of health insurance and wellness and the state initiative, talked about state led reform guided by spending targets for each state. None of the reports addressed the core of the Affordable Care Act, although some proposed changes in Medicare payments, in the Cadillac tax and in some other provisions that are not part of the core of the Affordable Care Act. None of them proposed Medicare premium supports; you know the principles in these efforts just considered it too politically toxic to take on at this point. Let me talk about Medicare provider payment reform. Many of the reports did not offer concrete steps to achieve goals for reduced fee for service. Many of the reports said, we want 75% of payment to be for methods other than fee for service by the end of the decade. How do you get there? Those reports are

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silent. That was unfortunate. For those reports that did specify how to get there, the levers tended to be provider payment incentives. Some talked about a permanent SGR fix, including some of the incentives for physicians to get into integrated, coordinated delivery systems. Some of the incentives for other providers were more controversial. There were proposals for second generation ACOs and Medicare and a lot of concerns were expressed that the current or the initial Medicare models had shortcomings and that particularly in their absence of beneficiary engagements. And they sketched out second generation ACOs as something that would expedite the movement away from fee for service. A lot of the reports talked about a redesign in Medicare benefits, all of them talked about a unified benefit structure, unifying part A and part B, at least from the perspective of the beneficiaries and the benefits and this unified structure would include catastrophic protection, co-payments for physician services, but being politically realistic, these reports envisioned leaving the existing distinct financing for part A and part B alone and basically ask the Medicare actuaries to be creative, to attribute spending to the different trust funds. Also, a number of the reports had particular proposals to discourage overly comprehensive supplemental coverage. Basically precluding supplemental coverage from wiping out all of the point of service patient responsibility. Only the Simpson Bowles Initiative addressed the Medicare age of eligibility.

There were a number of discussions of Medicaid and federalism with the focus on a revamping of the waiver process. Basically giving greater authority to the states to innovate and using state performance incentives on spending and quality, to go along with the greater authority.

I want to talk about the tax treatment of health insurance. A lot of people don't think too much about it and don't even realize that the Cadillac tax, which begins in 2018, is actually now our baseline. And that policies for tax treatment of health insurance needs to talk about changes from that baseline. Some of the reports focused on potential for a shift from the Cadillac tax approach of taxing premiums to the more long standing economist's approach about having limits on the exclusion of employer contributions for health benefits from employee compensation. Some of what we saw in these reports were that this could be designed for greater progressivity than we have under the Cadillac tax and the other advantage is that you are capping tax benefits rather than capping premiums, which the Cadillac tax perhaps inadvertently appears to be doing.

Let me talk about some opportunities and obstacles for moving forward. Another source of opportunity is the consistency of vision across the leadership of providers, payers and policy makers. And also the Affordable Care Act's provider payment cuts, which really start to hit later in the decade, are seen as pushing providers forward, making providers more interested in reform of provider payment, because that is coming. Also, I think the new thinking about federalism, we have had gridlock about Medicaid blocked grants for a long time and now there seems to be thinking on both sides about using shared savings approaches for delivery reforms in Medicaid programs. Now what are the key obstacles? One of them is the rudimentary state of innovative payment approaches now. This is very

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early in that game. There are concerns, I mentioned before that a second generation, some of these approaches may be needed soon and also there is a lack of readiness of many providers to succeed under reform payment approaches.

Another obstacle is the importance of consistency in payment approaches by payers. For reforming payments to really work, there has to be some degree of coordination between what Medicare and Medicaid are doing and what private payers are doing. Fascinating article in GEM about a month ago about a hospital really succeeding in the Medicare Pioneer ACO, but that is about it. It is subject to those incentives, the rest is [unintelligible] service. I think the traditional hostility in the public policy world towards demand side approaches is an obstacle, because I think demand side approaches have an important role in augmenting supply side approaches.

Finally, the polarization in Congress. To me, the absence of resolution on broad issues of entitlement cuts and taxes are holding up action on healthcare cost containment and we are optimistic now about – with this initiative where they are all working together to fix SGR, but I think the fact that they are fixing SGR in isolation as opposed to as a part of a broad reform, as part of a broad restructuring of spending, taxation, Congress is going to find that it is much harder to do it that way. Wait till they get to the pay for's, which I think are going to be much harder doing it narrowly than as part of a broad process. So I think the key thing that is holding it up, even though there is a lot of agreement and consensus on some concrete healthcare steps is getting the big picture deal about taxes and titlements out of the way. Thank you.

MARILYN SERAFINI: Great, thank you Paul. Okay, we are going to turn next to Len Nichols. Len is Director of the Center for Health Policy Research and Ethics at George Mason University and before that, he directed the Health Policy Program at the New America Foundation. He was the Senior Advisor for Health Policy at the Office of Management and Budget under the Clinton administration. Len is going to discuss the challenges and barriers to moving forward. We have also asked him to talk about lessons that policy makers can learn from the private sector. Len?

LEN NICHOLS: Thank you Marilyn. I would say the proposals that Rachel and Paul have described, do tend to have a vision of where they want to go. Where we all would like to go. Patient centered medical home, bundling, ACO's, etcetera. Alternative payment models in general. But as Paul said, they tend not to have a concrete road map of how to get us there. This rough road map is being worked out in both public and private pilots and demos and in some cases, programs, as we speak. It is this road map or you can even think of it as blueprint, that we need to construct in ways that work for heterogeneous providers and plans in our mostly private healthcare system. In my view, there are four groups of providers in the US healthcare system today. Those that are already there using risk adjusted global caps and non-fee for service payment almost in total; they are the remaining pioneer ACOs and a few others. Those that are trying to make the transition from fee for service and are mired in the messiness of doing it, with

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conflicting incentives and different reporting requirements from different payers, not all of whom are moving at the same speed. Those that are willing to make the transition, but don't have a cooperative payer plan partner where they are. And so they are kind of frustrated and they are kind of worried of simultaneously moving too fast and too slow, that is to say, they are worried about being left behind and they are worried about getting ahead of the payment so that they are sacrificing revenue without having any new payment to make up the difference for the reduced utilization. And finally, there are those that are implicitly opposed and will fight to hang onto fee for service until they retire or go concierge or are forced to switch. In my view, our job in the policy community is to try to help the good guys, that would be groups one through three, but frankly, it's not entirely clear to me that new policies required now, save maybe some more nimble and etrust authority and maybe a Manhattan project for preparing the payment reform models we need. I'm serious about this. If I was in charge of CMMI, which there is no danger of happening, but if I was, I would assemble a team of outside and inside advisors to work out the math of the road map and give it away as a public good. If you think about the Medicare physician fee schedule, it is essentially a public good for every plan in this country. They all use it. We need a new way of paying lots of different circumstances. Why not devote resources to producing that road map for us all? I love the fact that so many proposals mention the state. States clearly can play an important role here. Their Medicaid and state employees alone give them a big chunk of buying power, plus in some of the states, an increasingly more of them, all payer claims databases and again, some nimble antitrust, can be really key tools. But let's not kid ourselves. Medicare must lead, because Medicare is the biggest buyer and it can only lead if the private sector is willing to go where Medicare wants to take them. Hence, the public/private partnership is the catch phrase of the day. Now shared savings with states and simpler and/or broader waiver authority for Medicaid are clearly good ideas and it's really heartening to see so much support for that across the ideological spectrum. In any event, rewarding states for very simple metric like reducing overall cost growth and improving quality performance, is surely a good idea. The SGR fix, as Paul said, is an opportunity and a challenge. What is stunning is when you see everyone in town agrees it's really stupid to continue this policy, yet paying for it would have been a heck of a lot easier if we had been able to lace it in a much larger budget deal. Some clearly want a condition, the fix on participation in alternative payment model of some form that will ultimately make fee for service less attractive over time. When you think about that for five more seconds, that is not that different from what SGR is doing now. So the trick here is maybe not the formula, but the willingness of Congress to enforce reduced fee for service attractiveness over time. To make the transition to these alternative payment models, we must know what and how we want to pay the good guys. And by the way, think hard about who are the good guys. Are they the people who just adopt the alternative payment models and don't necessary control costs? Or are they people who control costs even with fee for service? I point out the vast majority of the patients in the medical home models and ACOs out there are using fee for service and shared savings as key component payment. Bundling, as much as I like it, it is a really cute idea, its full employment for economists, bundling cannot be

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done on very much of spend at the moment. Nor is it likely to be done on very much of spend any time soon.

The point is, fee for service is going to be with us for a while, which is why we have to get the ENM codes – evaluation and management codes, relative to procedure codes, right. We all know which direction that needs to move, but I ask you this question, is the medical profession ready to do this? I mean, really I would say policy if anything has deferred too long to the AMA dominated RUC or the review update committee. My view, we should blow up the RUC, give this authority to the IPAB, which will have the salient effect of getting the IPAB to come into existence. Okay, giving Medicare enrollees financial incentives is a really good idea. To use networks in medical neighborhoods, it should have been part of the original ACO rollout in my view and a lot of other people's view. It is coming in the private sector, that is financial incentives for taking a tighter network, in baby steps. Look at these exchange products and how many of them are limited. And so its definitely a poor tent for things to come.

Its interesting how many proposals mention doing something about MEDSUP. MEDSUP has long been a bugaboo of any efficiency hawk or economist and it's interesting to me that all the proposals, every single one of them, proposed restricting the kinds of policies that can be sold. Rather than taxing products. Now as an economist, I will tell you, you can structure taxes to drive most people where you want them to go, without denying the right to buy a mutually desirable product, which it is by definition since its being sold today. Denying the right to sell and buy, in my opinion, is very risky, it seems to me, in today's climate of hypersensitivity to freedom being taken away. The absence of the Ryan Premium Support in proposals is not shocking, but it is – too bad. In my view, it's too bad because that is clearly on the table in Congress. More broadly, the debate it represents, a major strategic choice we may or may not make between relying on health plans to enforce spending limits, our government set – with government set parameters as T. Or depending on providers to respond to public and private payment reforms. In other words, do you want health plans to run our system or do you want providers? In my opinion, our country is large and diverse; each will lead in different parts of it. The question is, who will set and enforce the discipline of the target global cap rates over time? It seems to me, no matter what, we are going to need government and private payers to incentivize providers to hit socially desirable growth rates with hybrid payment mechanisms. Again, IPAB might really help. I have always been confused by those who hate IPAB and love Medicare vouchers and vice versa. Take a deep breath, step back, in the long run they are after the same thing. Holding health spending per capita to something close to GDP growth per capita. There is a dispute perhaps over the level of benefits and there is clearly a difference in who bears the risk in case of failure. Tax payers in the case of IPAB, beneficiaries in the case of voucher premium support. But there is way more in common in these tools than the antagonist have yet admitted. And our health policy debates would be more honest and possibly even more productive if we analysts could help them see the essential similarities in the implications of their proposals.

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The Cadillac tax or simply capping the tax exclusion, are examples of where economists were in favor of political non-starters before anyone had ever heard of the Clinton Health Security Act, much less the ACA. I agree with Paul, I spoke to a convention of benefits brokers for high end self-insured firms last June, this is 2012, and their CEO clients had already directed them, number one issue, make sure we don't pay the Cadillac tax. Six years before it comes into being. That is a hugely impactful provision.

I would say overall, spending targets are possible, only when the pathway to success is clear, when the math is worked out and accepted and then performance can be fairly judged against an objective standard. Until then, we risk the same kind of toothlessness we have seen in the SGR. It seems to me, the biggest political barrier we have to sustaining lower cost growth, is the answer to this question – what will the savings be spent on? Deficit reduction or coverage expanse? The ACA answers the question one way and maybe the fight was harder than it needed to be, because the ACA was not coupled with a long run fiscal balance agreement. Maybe a long run fiscal balance agreement was resisted on its own because we did not yet have an ACA. Well, now we do have an ACA. So it seems to me, the ACA supporters ought to get firmly behind some credible version of a longer term fiscal balance agreement. Maybe this little but important and symbolic agreement that Congressman Ryan and Senator Murray have worked out, is the first step toward that.

The final point I would make is I was really intrigued in how many proposals talked about sin taxes. It is an interesting question. Would our support sin tax? Maybe this could intrigue the split between Grover Norquist and religious conservatives. Conservatives hate sin, but they hate taxes. I don't know, it gets confusing. Anyway, it's always been a good idea to do this, but be careful because the social economic status of the smokers suggests it's also a tax on the low income, unless you give them access to effective ways to end addiction at the same time. And it is that kind of trade-off, it seems to me, the reason you have economists on this panels. Thank you very much.

MARILYN SERAFINI: Thank you, Len. So before we turn to our last speaker, I wanted to remind all of our viewers on C-SPAN that you can submit questions that we will post to our speakers through Twitter. You can do that through #costconsensus or by sending us a direct message on Twitter at @allhealthreform. Also, if you are in the audience, you can again, once we get to our Q&A, use the microphones, but if you want to start getting your questions ready now, you are welcome to write them on the green cards and our staff will pick them up once we are finished with our final speaker.

So let's turn now to Sheila Burke who is on the faculty of the Harvard Kennedy School of Government. Like everyone on the panel, Sheila has a long list of credentials, which you can find in your packets. So Sheila spent most of her time in Washington working as Chief of Staff for Senator Bob Dole, both when he was majority leader of the Senate and also minority leader. She also worked on the staff of the Senate Finance Committee and

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also spent time as secretary of the Senate. Sheila is going to talk to us about the acceptability of the major components of various proposals. Sheila?

SHEILA BURKE: Thank you Marilyn and really my congratulations to Commonwealth and to the others who I think did a really spectacular job of bringing folks together, having Paul essentially do an array of what it is that was out there in terms of proposals, giving us an opportunity, I think in a positive way, to find where there are areas of consensus. And I think the opportunity for us to build upon some of the work that have been done in the past. So kudos to Commonwealth and to all the others – GW and others who participated in that process. As Marilyn suggested, I'm really being asked to give you a sense of what I think the political realities are of what has been put before us. I would also note that CBO has recently put out there ongoing health related options for deficit reduction, which is always an opportunity to sort of look at how CBO thinks about these issues and thinks about the savings that would be accrued as a result of some of these changes. So there is certainly a host of proposals out there. I would like to step back if I can though and reflect on, in part what Rachel mentioned and what Paul has described as at least the building blocks for what I think we might see going forward and where there might in fact might well be the opportunity for consensus. I have to say, as having been a staff member of the Senate Finance Committee for a long period of time, and on the Senate staff, I like to think of what occurred yesterday and what is occurring currently, actually in a very positive way. Not as a negative that they failed to do the pay for's. I think what it showed and in fact, was mentioned by Senator Dole, who was honored a couple of nights ago for his work on child nutrition, who commented that it was nice to see bi-partisanship coming back to the institution. And I think what we saw in Finance Committee in fact, what we saw in the Ways and Means Committee and the Energy and Commerce Committee, is the beginning of a conversation that we began a number of years ago, but we are coming back to, and that is a refocusing on the programs. And a refocusing on elements of the programs, which I think both sides of the aisle have an opportunity to look at, discuss and in fact already have found a number of areas of common ground. I think certainly it will carry over into next year, what we saw yesterday in the Finance Committee and what occurred in the Ways and Means Committee is the beginning of that conversation to take us into the new year where we will have an opportunity to look at greater detail at what in fact occurred and in fact turn to the pay for's as both Paul and Len have pointed out, but have not yet been identified. But the absence of that, I think in this early work, doesn't suggest that there isn't a willingness to take on some of those hard challenges.

So I think in fact what happened is in fact a very positive movement forward in re-looking at those programs and looking at changes that can be made. I think Rachel, in some of her summary and much of the work that Paul did, did identify some common themes and they are themes I think, that are broader than simply just the payment changes and moving away from, as Paul suggests, simply the provider cuts, which we have seen so recently. And really to broader questions. We heard in the discussions that occurred yesterday, issues around value. Issue around value versus volume. Clearly the SGR is a

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piece of that, but it's really a broader conversation about what we do with payment incentives and payment programs. A clear focus on quality. A clear focus on metrics, on looking at performance and essentially linking payment to performance. Again, something that has been coming for some period of time. Len very correctly suggests that there are some that are more ready than others to essentially engage in that, but I think shared decision making is an element of that. Rewards on all sides, how to figure out how to incentivize both positions as well as the individual consumers and systems, essentially to participate in those programs. Putting clinicians increasingly in charge. Again, to one of Len's points, there has been a long – a think a long term sense that in fact much of what was occurring was really at the behest of the payers, that essentially we drove either as public payers or certainly private payers and I think there is a clear interest in figuring out how to incentivize the clinicians themselves to become more actively engaged in the broader management of what is occurring in essentially in the systems and not simply in the silos that we have seen in the past.

Again, I think timing is always an issue. One might imagine, the changes that we have seen in the ACA that play out over a long period of time, some of the demonstration authority that is giving us the opportunity to look at different systems. But really, the readiness, as has been pointed out, is really quite variable. The opportunity to essentially analyze data. Use that data to essentially drive changes and behavior to try to drive certain kinds of behaviors on the part of the clinicians that are a part of systems. The access to that information, how it is utilized and by whom. That clearly is an issue that varies across the country in terms of how organized systems are. There are some, as Len suggested, that are much more readily able to access that information, utilize it in organizing their systems and there are those who are trying to make that transition; who are trying either in the development of an ACO or in some kind of organized system, to really access that kind of information. But it varies. Certainly bundling admittedly is limited to a limited number of circumstances currently, but the concept behind that is really about how we break out of the silos and really begin to look at the full continuum of care. The opportunity to look at what happens pre-admission, during an admission, post-admission and in a post accuted home and community based environment. Again, I think traditionally the payment systems have really encouraged those silos to exist and now through bundling and other efforts. What we are looking at is really an interest in looking at across the entire system. Now that obviously creates some real challenges. Some of those relationships do not historically exist, whether it's in the post acute environment in nursing homes and other facilities, in home and community based care when someone is discharged, but there is now a growing desire and I think a need to understand how do we help that patient manage over that period of time? How do we create payment systems to do so? Certainly the movement, whether its through ACO's or other organized systems of care, but I think in part the problem here is that the answer is not a single answer. We heard in yesterday's discussion for example, the Senate Finance Committee, some of the unique problems that exist in rural communities, where essentially you don't have the number of providers that are available or the kinds of relationships that are available.

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As we look at these system changes, and again as we look at some of what has been suggested in all of the proposals before us, we have to look at enormous geographic differences. Enormous provider differences. Again, that has to be adjusted in terms of what these solutions are in recognizing it won't be one solution. No question that there is an importance in the federal-state relationship and this is something that is clearly bi-partisan and that is the understanding of the value of the role of the state, how the state can incentivize certain kinds of behaviors. The states continue to have tremendous authority, whether it's over their role in the insurance regulatory environment, the point that was made about the networks and essentially the adequacy of networks is something that we need to be looking at. Certainly with respect to workforce, the demand on primary care, the increasing number of people coming into the system, will put pressure on it. And so we look at some of the incentives to essentially create more opportunities for more providers in those environments. Near and dear to my heart is the role of nurse practitioners and essentially whether they can practice to the full extent of their education. Physician's assistants and others – how we begin to look at team based care is also the focus, I think, on a bi-partisan basis. As people look forward from the payer side, how do we incentivize those kinds of things?

So there are a lot of elements in the proposals we looked at in some of the work that is taking place that I think do provide an opportunity to move forward, but there are also clearly deep differences and I think we would be foolish to ignore them. Certain the budget and the concern about the deficit. How we focus back on the healthcare programs, knowing that they are going to be caught up in this broader conversation about taxes and the entitlement programs. The lack of readiness on the provider level is clearly deep, is clearly wide and I think both parties will approach that somewhat differently, depending on what they are hearing from their constituencies. As was pointed out, the opposition to demand side proposals as Paul noted, no question resistance to increase cost sharing. It increased exposure, essentially, for beneficiaries, but on the other side real concern about how you get skin in the game. How you begin to have people pay more close attention. The issue around Medigap coverage is one of those issues that is essentially, how do you encourage people? Do you discourage the purchase of coverage that covers the first dollar? Do you otherwise try to incentivize their behavior in terms of their decisions and choices? The politics of these discussions inextricably linked to the tax discussion. What we didn't see, we saw extenders discussed in the Finance Committee, but we didn't hear anything about the tax extenders, which presumably will come out in the course of next year's discussion on a broader tax debate, which may bring back the broader entitlement debate. Varying demands from payers and payer systems. The lack of consistency among payers and essentially the way the providers have to respond to that. Do you essentially require certain kinds of behaviors or do you leave the open market system, as has been suggested. And how to incentivize the states? One of the basic issues that we have confronted in the Medicare/Medicaid discussions – particularly Medicaid, is how do you encourage the states in the concept of a dual eligible when most of the savings essentially accrue to the federal government because of the acute care side of the program. So again,

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how do you partner with the states, give them flexibility, give them ownership of those decisions, but none the less essentially achieve a broader set of goals?

So Len's road map, as he suggested, the sort of vision, I think he is absolutely correct. There are those who are ready, who essentially have the capacity. Those who are trying. Those that are willing to try. And then there are those who are, hell no, not until I retire. And I think the politics of the provider community, the politics internal to the House and the Senate and the discussions around the ACA, which have complicated that, will make some of these issues difficult, but I believe – I have to say, a glass really half full, that what happened yesterday gives us the basis upon which we can now move forward and refocus on the programs in their future.

And I would say in closing, the other thing we haven't touched on today, but I think we must touch on, is the federal government is a purchaser in a variety of ways and Medicare/Medicaid are not the only ways. Whether it's the Tri-Care Program, what we are doing with all of our systems, we have to begin to move forward in a comprehensive and a consistent way in terms of the way we organize finance and incentivize certain kinds of behaviors on the part of all of our systems and certainly those systems which have their own politics, have to be brought to the table as well.

MARILYN SERAFINI: Great, thank you, Sheila. While folks are getting their questions ready, I am going to go ahead and ask the first question and this has to do with the concrete nature of some of the proposals that are on the table right now. I would like to ask the panelists specifically about spending caps or spending targets. The way that the proposals are set up, would they really come into play?

PAUL GINSBURG: Well, you know, my sense from the proposals is that unlike an SGR where the spending cap drives things, the approach that a lot of these proposals took to spending caps was that they were a backup. And they were there for CBO. In a sense, what is different is that they were laying out concrete policies which if they work out, should actually keep spending below the cap and the cap is just a backup. And I think even as a backup, I think the notion would be that if it's triggered, the response is not a mechanical reduction in payment rates, but really a ramping up of some of the policies that were designed to lower spending.

SHEILA BURKE: I think Paul is exactly right. I think the experience with the SGR has caused people to be concerned about the role of caps, however they are constructed. How mechanical they are. We have seen that in fact since the inception of the SGR, you know, continued push back of what in fact would occur, so I think in designing any kind of a program like that, the question is, how credible is it? What is the result of it and in fact, is a backup or is it a mechanism that automatically comes into play and how that decision is made. But I think the SGR experience has resulted in people being somewhat cautious about how those are constructed.

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MARILYN SERAFINI: Okay, let's start here. If you could please identify yourself.

TONY HOUSNER: Hi, Tony Housner. I am quite pleased with the different proposals that have been presented today. I am interested in comments on which ones are most politically feasible and also would give us the biggest bang for the buck. If people could comment on two or three that you think would meet that kind of criteria.

RACHEL NUZUM: I will take a first stab at that. I think – and I would love to hear the thoughts from the other panelists, but I think at least from the Commonwealth's Fund perspective, our take of looking at all of these comprehensive proposals, was to identify the areas where there was the most agreement and more common focus and similarities and approaches. And look at those as possible areas for a path forward. So I think we have talked about many of those areas that we think tend to be pretty promising. The movement from away from paying for volume and to paying for value, this kind of widespread agreement of the need for more consolidated and aligned quality measures, I think this directional movement on price transparency, although many of the areas change. So that was really the goal of the project, is really to identify the main areas of consensus so that we could then go a little bit deeper and the groups could work a little bit more closer to the ground. But other folks might want to talk specifically about individual proposals.

PAUL GINSBURG: Actually speaking, not as a synthesizer of reports but as an analyst of healthcare, I believe that provider payment reform has some of the greatest potential to really move the dial and I think that is worthy of a lot of energy on the part of the Congress. I think the key thing is that you have to have a link between beneficiaries or enrollees and the organization such as the ACO that is actually trying to deliver the more efficient care. You know, without this link, I think that really limits it. So as I mentioned, Sheila and I were part of the bi-partisan policy center, we actually recommended an enrollment model where beneficiaries actually get an incentive to enroll in – we didn't call them ACO's, we called them Medicare Networks, I guess, which would – I think, pave the way for more success and also use the prods or the incentives of actually favoring the providers that are in that Medicare Network.

LEN NICHOLS: I would just add that I would say none of them are going to pass as they are written. Nothing ever does. What I would look through and it's precisely the point of the exercise, look through what is common across them and there you see where there is sort of things with traction. I would totally agree that payment reform are basically incentive realignment with market based tools like transparency and quality measurement and so forth. That has the most legs and I think the most potential for a bi-partisan agreement going forward.

SHEILA BURKE: I agree with all my colleagues. I would add one element and that is the whole question of workforce. I think there is in fact growing understanding of the need for team based care and a more collaborative environment rather than it all being

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driven by, in this case, physicians in most cases. But in investment in primary care, an investment in essentially incentives that create these teams so that essentially when we approach a patient, we look at them across a broad array of services. We increase access to services and I also think the emphasis on moving people out of an acute care setting into a home based and community based setting, I think the investments in essentially developing those assets and people that can care for folks in those environments and linking it again in a payment systems that rewards essentially that kind of coordination. I think there is a fundamental agreement and understanding of that and how that plays out state by state will be somewhat different, but I think there is an underwhelming commitment historically in doing those kinds of things and I think that is going to change.

PAUL GINSBURG: If I could say one more thing about – Rachel brought up price transparency. The point I want to make is that price transparency can be a – or transparency in general really, can be a very useful tool as an adjunct to something else. It really is an adjunct to different types of benefit designs where there are incentives concerning which provider you choose. Be an adjunct to different network type approaches. If you want the beneficiary enrollee to be able to get a sense of which network do they belong in or feel most comfortable in. But transparency on its own, I think has real risk of spinning wheels, doing damage, disappointing people, unless its hitched up to the perhaps harder policy to pursue where it plays a supportive role.

MARILYN SERAFINI: Okay, why don't we move over here and if you could please give your name and affiliation?

SPEAKER: I am Dr. Carolyn Poplin, I am a primary care physician. I have a brief comment rather than a question. You presented here what the consensus is among a wide swath of the policy community, but it's not among everyone. The focus in these proposals is utilization that the beneficiaries need to have more skin in the game. I think Commonwealth just produced a report saying that Americans have more skin in the game than anybody else in any other developed country. There is also great concern in the physician community, the American College of Physicians for example, represents its leadership, it doesn't necessarily represent its membership. There are health economists like Uwe E. Reinhardt, who think the problem is not utilization, that the problem is prices and its not physician prices, it is prices – at least under Medicare, its prices of imaging, drugs, tests, the three proton beam accelerators that we have in the Washington area. None of these proposals do anything about that. By the time your proposals kick in, the three proton accelerators are here and who is going to pay for them? That is going to be lumped into whatever fees are charged – bundled or otherwise.

RACHEL NUZUM: So I will start. I think those are important points to remember, that we did look at a very specified set of comprehensive proposals that certainly don't represent the totality of all of the ideas that are out there right now. I do want to clarify though and say that I don't think that the proposals were limited to looking at limiting

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utilization and I think in fact that is a criteria for selection of the proposals that we looked at and we didn't talk about all of the provisions, but I think another key element that was in many of the proposals was a focus on beneficiary engagement. I think that is different than having skin in the game. Getting beneficiaries really engaged and giving them more choice and in fact there is significant agreement among even some pretty substantial proposals into a different Medicare type benefit package. So I just want to clarify that its not all just about limiting utilization among the proposals that we selected.

LARRY MCNEALY: Hi, Larry McNealy with the National Coalition on Healthcare and thank the Commonwealth Fund and the Alliance for doing this. I wanted to return to a point that I think both Paul and Len made and then Sheila I think differed a little bit about the notion that, wouldn't it be great if the SGR reform was part of a broader agreement, something closer to a grand bargain broader titlement reform. I wanted to unpack that a little bit. Would it be possible, given where we are at now, we come to March and for lack of that breadth, if folks kind of back away from attempting to do SGR now and pay for it in smart ways, wouldn't we undermine kind of the confidence building effect that that would have? I would like to tease that point out a little bit from the folks at the table.

SHEILA BURKE: I don't want to have you misunderstand, I mean, it would have been great had the grand bargain been available and if agreement had been reached on a whole variety of things rather than the relatively limited package that is – has moved through the House and is about to move through the Senate and the separate sort of SGR conversations that will continue into next year. No question. I think a great many of us on both sides of the aisle have hoped that we would have a much broader conversation, certainly reflected in Simpson Bowles, certainly reflected in some of the work that Paul and I were involved in at the BPC and other places. The presumption was that the best scenario is one that has us look at this in a much broader context. My reaction was simply that I guess too many years on the Senate staff suggested to me that incremental isn't always a bad thing. In fact, sometimes the opportunity to begin the conversation to make some progress, lends itself to a broader conversation and I think what it did was allowed people to come back together and begin to work together in a bi-partisan way and we had not seen that. I mean, I don't recall the last time the finance committee had a markup, but it's been quite some time. In talking to some of the staff in saying, aren't you looking forward to it and having them say, I have never been through a markup before; it was sort of an interesting experience. So I think it's been three or four years. So I think even if it does nothing more than get people back to the table, get the staffs working together, what I understood was a wonderful collaboration between Senator Baucus and Senator Hatch's staff and similarly on the House side or the lower body, as I call it, on the other side. I think there was – I think there is an opportunity there. So yes, would it have been great to have a grand bargain? Absolutely. But I don't want to suggest that what was done wasn't in fact important and in fact lends itself to a broader conversation.

PAUL GINSBERG: Larry, if I could say one thing. What I was referring to was really that on doing an SDR fix on its own it seems as though the pay for us have to come from

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Medicare, whereas if you're doing it more broadly, there's a broader range to pick through and that's why I think it's easier. So that's where I was getting at.

LEN NICHOLS: And I would second that. All I was trying to say was the pay for's are much easier if you have a broader context. And I would certainly second Sheila's point that learning to do bipartisan, even if it's just at a birthday party, is a really good idea.

MARILYN SERAFINI: Okay, we're going to turn to this question here, and after that, we're going to go to a question that came in on Twitter, so I do want to remind our C-Span viewers that they can submit questions to us via Twitter at #costconsensus, or they can directly send us a Twitter message at @allhealthreform.

SETH TRUEGER: My name's Seth Trueger. I'm a practicing emergency physician and I'm also currently working in John Dingell's office in the House. One of the recurring themes we've been talking about for a long time is the shift from paying for volume to paying for quality and value. And one of the big levers for that is, obviously, pay for performance and quality measurement. I'm a big fan of this. Unfortunately, it's admittedly a science that it's in its infancy, and some of the implementation has been a little less than ideal, and unfortunately, there's been a big push back from physicians and other providers. I'm concerned. Are we creating a generation of physicians who are alienated from these sorts of approaches to quality measurement and pay for performance?

PAUL GINSBERG: I can answer part of that question. You know, what I've seen over the last couple of years is attention between measuring quality or value at the level of the provider organization versus a level of an individual clinician. And I think a lot of these approaches just are never going to work at the level of an individual physician and in fact I'm just really concerned with the attempt to try to do that, that, you know, at least for me, I think the focus should be to encourage the development of organizations that can take on these responsibilities because we're never going to be able to build the direct incentives into the Medicare program for individual clinicians that make sense to them.

LEN NICHOLS: I would just add that—and I certainly agree with the individual physician versus group point that Paul made, but I would add that there's a difference between measuring quality for a clinician to continuously improve their organization's performance and measuring quality for the purpose of computing value as we're talking about in these contexts. Now, the dream, of course, is for you all to inform the idiots who are making the payment right and that's why you have a process. I think what all of the proposals call for, I think, at least the ones that mentioned it, was more standardization—alignment, I believe was the nice phrase Rachel used—but standardization of the quality metrics that are being required. You know, I know of an integrated system in Virginia that is producing something like 249 quality measures for different pay. I don't know what the right number is. It's not 249. So, I think you've got to have this process, but

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God, you gotta start. I mean, we can't be paralyzed by the absence of perfection, and you know this, and so we'll go from there.

RACHEL NUZUM: Just one final addition. I think the other thing that's changed is that you have more people now talking about not just do you measure quality, yes or no, but having a more informed conversation about how is the data going to be used. And it's very different to get providers on board and there are some things that people are comfortable using quality outcomes for to make payment decisions and there's some that you just need to know as you are making kind of care decisions, you know, with the patient. So, I think there's a more sophisticated conversation going on right now about quality measurement, aligning those as Len said, but also, you know, before you're just collecting measures to collect measures, what are they going to be used for and this understanding that not everything needs to be tied to benefit decision making.

SHEILA BURKE: I want to underscore the point that Len made, and I agree with Rachel. I think it's a more complicated question today and a more nuanced one, but I think there was, in all of the proposals, and certainly the work that we did at BPC, a growing sensitivity to the myriad of indicators that people are being asked to essentially track, the cost, and the burden on individual providers as well as on systems, the desire to essentially simplify that process, make it rich but make it appropriate and more standardized so that we, in fact, can agree on the uniformity, or at least some kind of consistency so that providers aren't, you know, running multiple systems and the burden of that. So I think there is absolutely—I know Chris Cassel, who is now running NQF is investing heavily in understanding that and in the development of criteria, what they should be, how they can best be utilized. So I think there is a conversation taking place that touches on the very important issues that you've raised.

MARILYN SERAFINI: Okay. From Twitter: What is the one provider payment reform that Medicare or Medicaid could institute that would demonstrate a shift away from fee-for-service? And I'd ask our panelists to also give us a sense for the level of consensus on this one provider reform. Payment reform.

PAUL GINSBERG: Well, actually I can—one thing I want to bring up is in the BPC reports there was this very simple thing that providers that are part of Medicare networks or have episode bundling contracts with Medicare get higher payment rates. That would make a big difference.

SPEAKER: Right. I would agree.

RACHEL NUZUM: That's actually what I was going to say as well. There's a lot of commonalities among the proposals about, we've been talking a lot about the SGR, so, for example, exempting providers with a threshold amount, 25 percent, for example, of their patients or their practice and that, you know, one of these new provider arrangements, whether it's ACOs or primary care medical homes, or bundled payments,

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exempting them from, you know, the SGR freezes or the scheduled physician payment rates that would happen under SGR repeals. So that's one element that sticks out that would, you know—all of the proposals address that in some way. They didn't all agree on the level or for how many years but they all addressed how you deal with Medicare providers.

LEN NICHOLS: I think it's interesting that both of my very learned colleagues immediately talked about increasing fee-for-service for the good guys. And it just shows you how hard this is to move the ball really far really fast. I will go out a little farther on the limb and say some kind—I don't know exactly what kind—but some kind of PMPM to providers who are willing to demonstrate they can do coordination, you know, all the good stuff. And there is a start of that in kind of a cumbersome way in the ENC, on a bipartisan basis, and I think the Senate, too, now has a version where they would pay PCMH's basically for being NCQA certified. Now, let me make very clear. I'm on the board of NCQA. We're unpaid. I don't really think it's a great idea to have a new fee-for-service code, but I do think the idea of rewarding primary care entities for taking on responsibility. What I would like to do is link that to some kind of risk down the road, some kind of performance base. Maybe the thing grows over time if you bear more risk or whatever. The key to live here is getting the clinicians to be aware of the total cost to care. That is really hard to do, believe it not, in the current system for most primary care docs. There's no way to do it. What most PCMH's do in the country, first thing they do is show the docs the data. And docs are usually shocked. I didn't know that. And how could they know that unless somebody showed them the data. So getting the data in the doc's hands, getting the pathway to achieve the solution, i.e., teach and pair coordination, and rewarding them for the infrastructure they're going to have to build outside the fee-for-services system. That seems, to me, to be something that's building. I will hasten to say, the evidence on PCMH is its not thrilling, okay? I mean, they're pretty good at increasing quality. They're pretty good at increasing access. Cost evidence pretty mixed right now. So we have not yet designed the perfect baby. But anyway, that's what I would say Medicare could do with a little more oomph.

RACHEL NUZUM: Great. So, we have a question—a couple questions, actually, addressed to Paul, if you wouldn't mind kicking us off on this, and then Sheila and Len, if you could respond. But we talked about, and this is obviously a much broader conversation than we have time to get into today, but what do you think—and I know you've been thinking about this—so what do you think is going on with this healthcare spending growth flow down? Is it real? Is it going to continue? And how much of it can we attribute to potentially systematic changes coming out—probably not coming out of the ACAs, this question that asks, but, you know, predating the ACA, but healthcare systematic changes at the level?

PAUL GINSBERG: That was a very tough question. You know, for everything I've read and from panels that I've been to, clearly the recession and its aftermath were a very large factor in this. And hopefully that'll go away over time. You know, I said hopefully

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because hopefully the economy will come back. But you know, there does seem to be some evidence of some structural changes that would remain. Not from ACOs. They're too new. And when people have looked at individual ACO's, they're not saving a ton of money. You know, there's some evidence that, and David Cutler often talks about this, about how technological change has slowed down. And has it slowed down because it's running out of things to do? Is it slowing down because of the recession, because the market is not there? But, you know, I think some things we're going to have, you know, once the economy is restored, is I think we're still going to have much more payment at the point of service by patients; we're going to have incentives, too. We're going to have limited networks or incentives to use some providers rather than others. I think there's a lot that's going to be continuing in a stronger economy, and I think that will have an effect. So, I'm optimistic that some of the slowdown in spending will be maintained and probably, but probably won't be as extreme as it's been in recent years.

LEN NICHOLS: I think it's really fascinating to observe that the slowdown actually began a couple of years before—began in 2007. It began before the recession really hit. And so certainly the recession contributed to it, no question about it, but it already started. So what's the deal here, and then what is continued? I think, you know, we're speculating here so I would just say, in my opinion, it has to do with the fact that a critical mass of healthcare decision makers had figured out, we've got to do something about our healthcare system's cost growth and I start with employers sending the signal. Not that they really know what they're doing, but they're sending the signal: we've got to find cheaper ways to do this. Hospital leaders. I've never seen hospital leaders so unanimous in being aligned around this point—we've got to reduce costs. Before the ACA. What the ACA did was kick in and turbo-charge it and really lay down a marker—we're not going back. Because let me tell you a secret. That market basket update reduction is real. It takes money out of hospitals forever basically at an increasing rate over time. And that ain't changin'. The penalty on readmissions, which gets worse over time. These things have focused the minds like never before and so I think there has been a system-wide kind of okay, I guess they're serious this time, and some of that is going on. But I think everything Paul said is right. I think the technology thing maybe is important in the short run as anything else.

SHEILA BURKE: I think it's both. I think it's a combination of all the things that have been touched on. I think there will be elements that will be sustained, but I think we're also looking in terms of the aggregate, at this bubble of baby boomers that are coming through the system that will certainly put enormous pressure on the system. But I think many of the elements that were contained in early work and the sensitivity that Len suggests on the part of payers and employers and others I think that's not going to go away and I think that many of those kinds of changes will be sustained.

MARILYN SERAFINI: Okay, let's go to this microphone.

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AL MILLIKEN: Thank you. Al Milliken, AM Media. What more do we know about increased costs for emergency care, also for delayed treatment of known and medical concerns and conditions? Can we make comparisons with these similar healthcare costs in other nations? And I just wanted to mention, in my own personal medical experience this year, I got a referral in August from my general practitioner. I wasn't able to get an appointment with a specialist until the end of November and then when I needed to be treated in September, they told me to go to the emergency room. That had to be more expensive, I think. I made two emergency room visits in September, then, as a result of that.

LEN NICHOLS: I don't know if we know anything more in terms of what you're asking than we've known for quite a long time, but I think what's fascinating in part of your story is that when you look at—and maybe I'm kind of focused on PCMH's—when you look at what PCMH, what hospital—what physician groups have to do to qualify for the private sector design PCMH's, which, by the way, are by far the largest number, okay—the first thing they have to do is figure out a way to give 24/7 access. And it could be that they have to have a nurse on call and they call them whatever, but they have to find a way to address the question of a human being who needs care outside the 9-5 situation. That is a precondition for getting the payment bump up, or whatever you get to join the program. And so I think it is unambiguously true that we have learned, 'cause payers are willing to pay for it, that 24/7 access has a cost reducing effect. It also has a beneficiary happiness effect, 'cause you're not pissed off if you don't have to wait and all that stuff. So these two things are both part of holding consumers in there. But we know going to the ER when you don't need to go to the ER is ridiculously expensive. We know that delaying access to specialists may very well delay, you know, go from stage 1 to stage 2, that kind of stuff. All that has been known for quite some time. I don't think that's anything new there to learn.

RACHEL NUZUM: And you asked about international comparisons. I mean, we also know that, you know, we're paying more than any other industrialized country for health care both in total and per capita, and Americans are much more likely to go to the Emergency Room because they don't have access to a usual source of care than anywhere else in the country. I don't think we have really good emergency room metrics.

PHIL GINSBERG: You know, one thing I thought of that might also be a factor is the distortion in our Medicare fee schedule. You know, the fact that we pay so much more generously for procedures than for visits may have had something to do with your having to wait months to get an appointment for a visit with a specialist.

SPEAKER: I'm going to take exception to that as a specialist, if I may.

LEN NICHOLS: Well, go ahead. It's your turn.

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SPEAKER: It's my turn, but I don't want to respond to that question but I will. I mean, three to four months is ridiculous, I'll agree with him. But I don't think that the difference in pay has anything to do, because specialists are overrun just as much as anyone trying to do clinics right now. There's as much a shortage of specialists as there are primary care. And I think one of the other things; before we jump on the primary care band wagon, look at the training of the primary care docs now compared to the primary care docs 10-20 years ago. [Unintelligible], Pediatric Cardiology. Just as an anecdote, and Len knows this. Before I left to come to Washington I looked at who was coming into our clinic and over a 5-year period we had a 20 percent growth of new patients into our clinic with real heart disease and a 300 percent growth in patients with functional disease that should've been cared for by the primary care doc. Why did we have to see that 300 percent increase, which ends up delaying the patient with real disease coming in? So, before we get into this, remember we have to get down and look at a few other things, and that's my segue into my question. A few other things is training. You got to look at training. Look at how they're being trained. Second, it took us an hour and a half into this program before Rachel mentioned data, then Len, of course, hit it out of the park, mentioned it four more times. Paul alluded to transparency. But without the data what is it—why do we do it? And I think Len's comment about doing a Manhattan project is great, because some of us still look at HIPAA—well, I almost said it, initially. CMS is kind of divided into this two—it's schizophrenic. It's the HCFA mentality of paying things and keeping the data away from the physicians until it's complete, and not getting it for two years. My being paid on a quality basis of what I did in 2013 and paid in 2015 is like what we were taught not to tell the mother who said, Johnny, you were bad. Wait till Dad gets home to spank you. You've got to put it in the context of when you're doing it, so are we going to have a Manhattan Project? Will CMS get the infrastructure to get timely data to the physicians so they can make the improvement? And I'll also tell you that right now a lot of the associations that are doing the quality measures are starting to say what's in it? Where's our ROI as an association? They're stepping back from that because to put it registry together, for instance, to collect the data is a million dollars, and they all don't make money for four or five years. So, I just bring that up that Len hit upon the fact that when a physician sees their data they change. And I bet you'll see more change with physicians getting timely data and comparing them to what they're doing—against their peers locally, regionally, and nationally, giving them tools to change than you will by any payment model, whether it's fee-for-service, bundled care, or incentives. So, just—

SPEAKER: One thing I just wanted to add, from my own experience, the specialist told me later, when I just saw them a few weeks ago, that if I was already in the system they probably would've seen me. But that was like a first-time referral so that was the reason they told me to go to the Emergency Room. That's what they explained to me, anyway.

SHEILA BURKE: This is not meant as a political comment, but I think the likelihood of CMS getting a great deal of new money any time soon is unlikely. But I think there is a great deal of sensitivity to the timeliness of data. I mean, one of the issues that Paul and I

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contend with in the work that we were doing with BPC is the age of the data. I mean, this has been a long time problem with respect to Medicare. I think Len's exactly right; that one of the credibility issues with respect to sort of the indicators in quality has, in fact, been the time lag between essentially the acquisition of the data and the analysis of the data and the practice. There's no question that we have to find a way to make things more relevant, more current, and more credible as a result so that people can essentially believe that, in fact, what they're being given is a basis of how much they can make change. But I don't—in the near term—see commitment for a Manhattan Project, but I think the point is a good one.

LEN NICHOLS: So, I've got to say, you know, there are many things I don't understand in life and I would start with the [Unintelligible] rule, and the American League, and then the Chinese language, and third, how come it is that the private plans can get you data with a one-quarter lag and they be clear, the private plans do the processing for Medicare, but somehow Medicare can't do it if you [Unintelligible] in two years. I do not understand that. And I don't think you need more money, Sheila. I think you need different people. I just can't figure this out.

SHEILA BURKE: Could be.

RACHEL NUZUM: If you're going to speak, please join us back at the microphone.

SPEAKER: My understanding in Medicare, you have a year to submit the bill and they wait till all the billing is in and something like that.

LEN NICHOLS: The insurers have the same lag.

SPEAKER: But they're doing it boom, boom, boom, boom, boom, and they're doing it—they're doing it on a rolling average, where Medicare waits for accumulation.

LEN NICHOLS: Do not let perfection stop the good because it turns out—all I know, all I know is what private plans are giving docs and somehow it's enough to get the good guess here. Anyway. Seems silly to me.

RACHEL NUZUM: Okay.

STUART GUTERMAN: Hi. I'm Stu Guterman with the Commonwealth Fund. A couple of observations on the points that have been raised here. One is, on the distinction between rewards and punishment. I think one of the encouraging things that I see across all of these proposals that we've been talking about today is there's an emphasis on changing the payment system so that you reward good behavior. And we need to start thinking about the healthcare system like that. It's not about punishing bad behavior; it's rewarding good behavior because right now we reward bad behavior. So that's, you know, that's got to be a change in the way we think about things. And also about the

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trend in healthcare costs. I keep being reminded, when people start debating about whether healthcare costs are really slowing or what's caused the slowdown, is that I get the sense that it's a spectator sport, and health spending is not a spectator sport. It's something that is generated by millions of decisions every day, and it's an ongoing thing. So whether or not healthcare spending has slowed because of the recession or because of structural changes, we need to make sure that whatever happens in the future sustains a level of health spending that we find sustainable, and that means action and not just sitting back and watching and waiting. And I think there's action on that front. There are both public and private initiatives that have been shown to have been pretty promising. One of the private one that we've done a lot of work on is the Alternative Quality Contract in Massachusetts which Blue Cross/Blue Shield in Massachusetts has done. And what they've done is, one of the encouraging things they've done is they've actually taken data and shared it with providers to compare their behavior, not only with other providers in the state but also other providers, even in their own practice. So, Dana Safran of Blue Cross/Blue Shield will tell a story about how she'd go in to doctors and point out that the doctor next door was prescribing a different, much more expensive drug for the same condition and the doctor that she was talking to, and the doctor she was talking to just didn't know. So I think getting—that kind of transparency—and I agree with Paul that transparency that's hitched to some workable legislation rule situation has to be, has to be done. And the last point I'll make is, one of the things that drives me crazy about people talking about health reform is this notion that there's a shrinking pie. People talk about blood running in the streets because providers are fighting over a shrinking pie. If we're talking about health spending growing at the same rate as GDP, we're talking about over the next 10 years there being on the order of 50 to 60 percent more health spending 10 years from now than there is now. I posit that only in healthcare would that be called a shrinking pie.

RACHEL NUZUM: Great. I'm going to go to one on the cards and then I'll come to you for your question. So, we're going to shift gears a little bit. Len, you had a question about what you believe the rule of Antitrust should be with respect to healthcare reform efforts and what you may have meant when you said the need for more nimble antitrusts.

LEN NICHOLS: Yeah. Good point. I was hoping somebody'd take that bait. So, here's the thing. Any trust is complicated but it is kind of mired in the past in that it really is sort of focused on structure and predictions of performance and basically I would say there's been a tremendous emphasis on organizations proving clinical integration efficiencies before a merger is approved, but they tend to lose in court and so they got frustrated over the years. And my point would simply be this: sometimes antitrust needs to be more, in my view, accepting of the proposition that, indeed, new vertical integration and new virtual integration agreements may be more worthy of getting a pass than they have in the past, but also we need to be aware—and what I mean by more nimble—sometimes the antitrust remedy is just too cumbersome for current law. There is very little you can do about local market power if there's one hospital, or, no matter what you wish, already one group of cardiologists or orthopedists or whatever, be it pediatricians, so that, you know,

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they can hold everybody hostage. Well, if you're in that situation, antitrust is a very cumbersome tool. You mean to think about—I mean, I hate to say it, but I will—you need to think about regulation in that context. I think of regulation as the worst case last door, 'cause I'm an economist, but in the absence of anything else what do you do? Well, the one thing you could do, and this is what I would mean by maybe allowing a little bit more nimble permissions, I think domestic medical tourism is greatly underused. I know a retired surgeon in the Denver area, six months into retirement got bored out of his mind like most of us will, called up a mining owner he knew and he said you're paying too much for healthcare and I'm bored, let me help you. And he looked at his data and he picked 15 conditions that were the most expensive conditions and for mining companies it's basically shoulders and knees and hips and stuff. So he found the 15 best places to get each of those procedures done in the upper Midwest and, by the way, all of them had lower prices than a lot of places they were going and they had way fewer complications, and mistake rates, etcetera, etcetera, etcetera. The problem was getting the miner from Wyoming to go to Denver or some other place. So they used cost sharing in the plan from the—and, you know, a self-insured employer can do all that sort of stuff. But they really, if you will, threatened the local monopolies with I'm going to send my people over here unless you come back. Well, that's kind of a brutal form of reference pricing. In my view, you've got to let that sort of stuff go on and encourage it. And, then, by the way, the guy told me the biggest problem he had was getting the guys from Wyoming to go to Denver 'cause they were afraid they'd get robbed in the parking lot when they came out.

PAUL GINSBERG: If I could follow up, I think, like Len, say that antitrust policy can be beefed up, but that's not going to be—it's very cumbersome, even beefed up. It's not paying any attention to these combinations between hospitals and physician entities which, I think, is a real concern to me. But there are a whole range of things that are market oriented that either, as Len was saying, can be done by purchasers, payers, or in many cases they can be facilitated by government. For example, one approach is the tiered hospital network which is very difficult to get off the ground because prominent hospitals can say, you know, put us in the best tier or we won't contract with you. Massachusetts passed legislation banning that. So I think there are real opportunities at the state and federal level to not necessarily take a regulatory approach but to take action which actually, you know, fosters freeze up market approaches. Another is fostering physician organizations which can be done by insurers. It can be done by governments. In fact, you know, under CMS and the ACO program, you know, has some special provisions to encourage smaller physician-led ACO's to come into the program. And, you know, that's the type of thing we need more of.

KYLE PEDDICORD: I'm Kyle Peddicord with the International Association of Firefighters. One of our biggest concerns is the Cadillac tax. So when Dr. Ginsberg mentioned replacing the tax with a limit on the exclusion for employer provided healthcare that was the first time I heard that idea, actually. I'm intrigued by that proposal, but on the theme of encouraging good behavior, discouraging bad behavior, actual effects on employees, employers, insurers, how this moves money around, what it

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actually means, I'm interested to hear more about that in addition to the political realities of whether that's something that actually has legs or not, but, primarily, just how it would work.

PAUL GINSBERG: You know, I would think from a perspective of firefighters, you know, the problem with any of these approaches—the Cadillac tax, or a cap on the exclusion—is that, you know, some employed groups just due to the nature of their work or the nature of their workforce are going to have higher medical spending. So that's really a challenge of making these policies sophisticated, sensitive enough, to adequately recognize that. You know, I think the—and this applies both to a Cadillac tax and to an alternative—and actually the BCP report had that, but I think that, you know, one of the most concrete things is—the difference between the two—is that just the way it works out. The Cadillac tax is effectively a de facto cap on premiums that just given the fact that the insurers can't deduct the taxes, it's really, you know, that they'd have to charge so much more for anything above the cap they won't do it, and that's really, you know, much more limiting than an approach which is just dealing with the incentives and saying you can have a policy with a higher premium than this. It's just that you're going to do it without tax subsidies for that last part of the premium.

SHEILA BURKE: As Paul suggests, there is a difference in terms of the impact. And, as you've pointed out, the difference in the impact in terms of the employer and the employee. And, as you might imagine, again, as Paul suggests, that depending on the cost of the plan, the industry, the group that's covered by the plan, the nature of the plan, it does have a differential impact, so you might imagine that large employer plans, historically some large union plans, there have been a fair amount of opposition to these kinds of changes. And so, when you look at sort of the political realities those are certainly stakeholders who would have strong views on this question.

RACHEL NUZUM: Great. So I think we're down to our final couple of questions, and we've had the majority of this conversation focused on areas of consensus and have steered pretty clear from the Affordable Care Act. But let's bring it back to that specific topic. And this question asks whether the addition of millions more insured under the ACA poses an additional challenge or an additional hurdle for healthcare cost control. And I might also ask folks to think about if there are additional opportunities embedded in there as well, but now that we're enhancing the pool of folks that are going to be insured under the Affordable Care Act, whether it's in the private marketplaces or in expanded Medicaid situations, are we facing additional hurdles or opportunities in getting a handle on healthcare costs.

PAUL GINSBERG: Well, you know, actually, I think a major positive of, you know, expansion of coverage is that I think there'll be fewer concerns on the part of providers that if they do practice more efficiently, if they limit hospital admissions, that, you know, this is an environment where you can do that and won't suffer as much. You know, for hospital. So, whenever providers are very busy presumably they're much more receptive

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to ideas about how they can practice more efficiently. And you really see it in hospitals that, you know, if the hospital is worried about empty beds it's going to be very different than if the hospital is worried about I'm bursting my capacity and I don't have the capital to expand.

LEN NICHOLS: I think that's an excellent point. I would also suggest that, you know, when you get right down to it, what the law does, at least in my opinion, is focus many more, not all, but many more players in the system on population health as opposed to taking care of me and mine. Once you require all insurers to take all comers you really have a different world and that world has not yet come to be. It will come, assuming we can get the website up, sometime in '14. And that will be a different world, and that will be a world in which insurers will have to change their business model. And their business model will move from partially, and maybe in some cases, mostly risk selection to helping all enrollees find value in the healthcare system. There will be a blip in aggregate spending. That goes without saying. I mean, yes, total spend will go up in the blip, and because we're going to phase in Medicaid, apparently, it'll take four or five years for the whole blip to be in. But the key variable in all of this, in all of this discussion, is the rate of growth of cost per capita. And, in my view, if you've got more players focused on population health, you got more providers willing to take the leap because they're not going to go broke, and you got more plans focused on value, that allows the system to deliver value and you got more people interested in developing incentives for that value to be sustainable by providers. So, in my view, it's actually easier to contain cost growth in the long run with everybody in.

SHEILA BURKE: I think this is one of the areas where it's going to be an interesting scenario to watch between the state level and the federal level and what occurs in those different pockets of expansion, certainly with respect to Medicaid. We've seen in recent years the large majority of plans for their existing population have chosen to put them into managed care arrangements. One might imagine, and even in the course of the conversations around the new expansion in those states that have chosen to go with a different strategy and with those that have chosen to expand, again, the states have sought out and are looking aggressively for opportunities to essentially organize and pay for services in a different sort of way. So you might imagine, with the increase, if we're looking at 7 to 8 million people coming in successfully into the Medicaid expansion in the coming year that, in fact, there'll be even greater pressure on the states to look for those opportunities. As Len suggests, the enrollment through the exchanges and the exchange base plans, lends itself for insurers to look for opportunities and methods for organizing and financing care in a more efficient way. One way might well be the way they construct their networks, a point he made earlier, that we're only beginning to see what these plans are going to look like; the rates they're going to pay, how they're going to organize services, what those networks look like, what tools they utilize to essentially organize that care and keep those costs down. And certainly the uncertainty, in part, about what the risk pool is going to look like because of the slow enrollment is going to complicate things in this first year. So I think it's really going to be a couple of years

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before we really see how that plays out. And the ability of the insurers to anticipate and plan, but certainly, the underlying insurance regulatory changes have put pressure on them to figure out how to manage this population differently. So, I think there really are some opportunities here, but also, frankly, some real challenges.

MARILYN SERAFINI: Before I pose the last question I just want to remind everybody, on the right side of your packets is a blue evaluation sheet. I would ask that you take a moment to please fill it out for us. So, I'm going to pose one last question to the panelists, and it has to do with 30 percent of patients accounting for 70 percent of total healthcare costs. The question is how do we balance between targeting this high-cost group first and benefiting the other 70 percent of the patient population so that they receive better outcomes and high quality care?

SHIELA BURKE: I think those are common themes and common strategies. If one can imagine figuring out how to manage that population that are extraordinarily expensive but that can only work to the benefit of the general population in terms of how we organize and think about services, I mean, there's no question that there's increasing attention on, particularly, the duals—people that are eligible for both Medicare and Medicaid, the 8 to 9 million people. We know they are extraordinarily costly. We know that there are efforts to essentially look at the relationship between the state and the federal government in finding new ways to manage those patients, how, essentially, to keep them out of acute care settings, how to essentially manage them differently. So, I think that can only benefit the broader conversation about how you rethink the way we organize and manage people over the full continuum of care. Common strategies, obviously more acutely necessary with very high-cost patients, but certainly to the benefit of all.

LEN NICHOLS: So, I would look at what REAL plans are doing and, in some cases, the Medicare demos are doing, and what you see is, I would say, sort of three kinds of patients they're focused on. There are those that are really, really sick already and you've just got to do the best you can, and that's care management and, you know, full speed nurse manager at the side. Then there are those who are in this co morbid position that use a lot of money, use a lot of services, but they could be managed much better if they were coordinated, etcetera. That's where people are throwing the new infrastructure. Then there are most of us who are healthy most of the time. We don't need much. A little email, maybe some encouragement when you got the cold, but it's really true. It's mostly about consumer service there, and then it's about preventing that 70 percent from getting the condition or having a condition deteriorate and put you in the first two groups. So it is about monitoring. And you do not want to ignore them, but they don't need near as much infrastructure as the 30 percent. What PCMH's are finding is that they actually do better on ROI if they focus their infrastructure on those that are in that 30 percent. Now, they're not unmindful of the other ones who come in, and Lord knows, if something happens to you and you fall over the chair, then you get in the group that gets more attention, but you don't need that much attention. In fact, most Americans would balk at that much attention

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until you get really sick. So, I don't think it's that big a problem, as long as we get the infrastructure spread.

MARILYN SERAFINI: Please join me in thanking our panelists for shedding light in areas of consensus when we talk a lot about differences in this town. Thank you very much.

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