ALLIANCE FOR HEALTH REFORM

Expanding Access to Care: More than Just an Insurance Card?

Alliance for Health Reform
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ED HOWARD: I want to welcome you to this program. My name is Ed Howard with The Alliance for Health Reform. Thanks for braving the hot weather in Washington to come to this program. You probably remembered how cold you were the last time you were here and thought that was a great idea to spend the August afternoon in the air conditioned comfort of the Columbus Club. But that is not all you are going to get for your money. You are going to have one of the best programs you will have a chance to be part of on the extent to which efforts to reform the health care system will affect the access to health care.

And I want to welcome you on behalf of Senator Rockefeller, Senator Collins, and our board of directors, and you will have a chance to be welcomed by our board of directors directly here in a moment.

Awhile back, I turned 65, and became eligible for Medicare. I got my card in the mail, but I knew that getting that card actually meant I had to go out and find a new primary care doctor because my previous one did not accept Medicare. Now I eventually got a fine primary care physician and I appreciate your concern, [laughter] but the point is that having insurance is very important to getting access.

After all, the Institute of Medicine estimates that 18,000 Americans die every year who would not if they had insurance. But there are other factors beyond holding an insurance card that affect whether you actually get the care you need and we are here today to talk about some of those factors.

We know for example that there needs to be enough primary care docs and other providers if people are going to have adequate primary care access and that a lot of young professionals are not going into primary care in our med schools and associated schools, and we know that relative to specialists, primary care providers have substantially lower incomes and the way they are reimbursed, the way most physicians are reimbursed, that is to say a fee for a service offers no incentives for caring for patients in the most efficient, high quality, effective way.

Now, our partner and our cosponsor in this enterprise, the Robert Wood Johnson Foundation has a very strong interest in this topic. They self identify as working to help Americans lead healthier lives and get the care they need, so we are very pleased to have their involvement in the formulation and the execution of this forum. I want to thank Risa Lavizzo-Mourey, David Colby and their colleagues at the Foundation for their interest and support.

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A couple of quick logistical items, there will be a webcast available tomorrow on Kaiser Family Foundation's website, kff.org. You will also find copies of the materials in your kits and the biographical background on our speakers far beyond I have the time to take to give you today. You will also find all of that material on our website, allhealth.org. If you are watching on C-SPAN, everything that the people have in front of them on paper is on our website, allhealth.org. You can follow along even with the presentations, the Power Point presentations, if that is what you want.

At the appropriate time, those of you who are in the room can fill out the green question cards that are in your packets and hold them up and we will ask the questions that we can get to. There are microphones at the front and the back of the room that you can use to ask a question yourself and at the end of the briefing I'd appreciate your filling out the blue evaluation forms so that we can improve these briefings for your usefulness.

Now, let me get to the program. We have a terrific group of panelists today. National respected analysts, people working on the ground to improve access and they are going to give you brief presentations and then we are going to turn to discussion including your questions and we are going to start with Susan Dentzer.

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Susan is the editor in chief of *Health Affairs*, the preeminent health policy journal in America, as well as an on-air analyst on health issues for The News Hour with Jim Lehrer. They know her pretty well over there, since she has spent a decade leading a reporting unit focusing on health care and health policy and social security.

If you rely on *Health Affairs* as I do for health policy insight, you will have a sense of both the breadth and the depth of Susan's expertise. And we have asked her today to bring us up to date on what is actually in the major reform plans being worked on Capitol Hill in the relevant areas. Susan, thank you for joining us. We are glad to have you with us.

SUSAN DENTZER: Thank you very much, Ed, and by the way, belated happy birthday. [Laughter] It is great to be with you all this morning and to me has fallen the rather dubious task of attempting to summarize what is in the health care legislation in ten brief minutes. Some of you may know that the house walked through this a couple of weeks ago and it took them more than three hours, so you are going to get the speed read version of this.

But I just want to begin by saying, to underscore Ed's point, that access is about more than having just an insurance

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card, and indeed everything in these bills in some way, shape or form is about access.

Sometimes you hear people say this is an access issue, this is affordability issue, this is a cost issue, you really need to think of these things as being all very much interrelated, and it would be great if we could just have the luxury of dealing with one problem at a time, but we do not unfortunately.

We know a lot about the strengths of the U.S. Health Care System based on the research of the last dozen years or so. We also know a lot about the weaknesses and we know that we are going to have to work in a lot of different arenas, even just to deliver on something that sounds as simple as access, so that is really what these bills are about.

Let me quickly move through my slides here. I am going to quickly talk about the Obama Administration's reform frame work, the top priorities of health reform, and some emerging details of key bills, and now I am already down to just nine, so here I go.

As you know, there is not an Obama Plan, not withstanding what you read; even in the *Washington Post* today there was one story that mentioned the phrase Obama Plan about ten times. There is not an Obama Plan per say, there is an

Obama framework in while the bills coming forth at Congress are now being organized.

And you see even in the president's eight principles the attempt to address all of these issues, reducing the high administrative costs, reducing the rate of growth of health insurance premiums, of aiming for universality of coverage, that is moving toward a universal coverage system so that more people have access, providing portability of coverage.

You can have access to a health insurance policy in one job and then lose it in the next if your next employer does not offer it, so the portability of coverage is even an issue, providing a choice of health plans and physicians is an important feature of access for many individuals. Investing in public health measures in order to keep coverage affordable over the long run, we are clearly going to have to have a healthier population.

So, if you have health insurance that is too expensive, because most of the population is obese, you are not going to have access to health coverage, so again underscoring the point that all of these things are very much interrelated.

Now, the primary goals of reform I think could probably be summarized into just these three, insuring access to good health coverage, we do not want to ensure access to bad or mediocre health coverage for as much of the population as

possible. We do want to cover the uninsured but we also very importantly want to bend the health care cost curve, because otherwise nobody is going to be able to afford access, even the people who are currently insured.

Just to briefly recap, we know how people basically below Ed's age get health insurance now; most people get it through the employment based system. Some people do buy it privately in the individual insurance market. Some people get it through Medicaid and of course some people are uninsured.

How do we broaden coverage in all of the bills? Well, we actually are proposing to take all of the existing mechanisms and stretch them, so you can think of various sort of safety nets of health coverage, every single one of those would be stretched under the congressional proposals. We would shore up the employment based system.

We would create a new pathway for other people to get insurance that is not strictly speaking through the employer based system. We would expand the safety net, particularly Medicaid, for poor and low income people, and as I say some combination of all of the above is to be proposed in the bills.

Now as I mentioned, the cost piece is extremely important here. This is a chart that we ran several years ago in *Health Affairs* that makes the important point that over time, national health expenditures, which is that top bold

line, have been growing about two percentage points faster than per capita real economic growth, per capita real GDP, and this has basically held pretty constant over time. There will be some differences this year because we had an extremely weak economy, but more or less this formula has held to a surprising degree.

Now, why is that a problem? On one sense you could say well that is great, it means the health economy is booming. Yes, but this is a piece that Mike Chernew and some of his colleagues at Harvard did for us several years ago. They will be updating this in our September issue, which is about bending the cost curve, so stay tuned for the new numbers.

But essentially what these economists did is look at what happens if health spending grew at his 1-percent faster than real GDP versus 2-percent faster than real GDP, what would happen to all the other resources we would generate in the economy over this time, their calculations of several years ago showed that if we managed to slam on the breaks and bring health spending down to just 1-percent faster than real GDP, we would devote 55-percent of the entire increase in U.S. national income from now for the next 75 years to health care.

That is if we slam on the breaks of health spending, which would mean we would have 45-percent left over for everything else: Defense, education, the national parks, you

name it, everything else you want to do with your life that is not about health care, 45-percent of real growth in the economy would be left over for that.

If we go at two percentage points faster than real GDP, what happens? 124-percent of increase in real national income goes to health care, which is a way of saying everything we are now spending on health care goes into real GDP, all of the increase in real national income goes into it, and we suck away resources that we are currently spending on other things.

Ask yourselves how affordable health coverage will be in an economy where nobody is doing anything else but working in a health care system or buying health care. As Herbert Stein, the famous late economist once said, things that cannot go on forever will stop. We can be pretty confident this will stop but it is not going to stop on its own. We have to figure out a way to put on the breaks.

So, how do we deal with all of this? Let us take the piece about covering the uninsured. Most of the bills foresee a Medicaid expansion, primarily aimed at picking up those people who do not now have coverage, who are in fact poor, it is a dirty little secret of our program for the poor that it does not cover about half the poor, so we are going to stretch that safety net and you see that the proposals cluster around

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this notion of expanding eligibility to 150-percent of the federal poverty level.

New pathways, we have to figure out a way to give more of the population avenues to get health insurance that more closely resemble what people get if they get employment based insurance.

If you are in an employment based insurance plan, you are in a big pool. Your risks are spread across the entire pool so that sick people do not have to pay more than healthy people because in effect all the insurance risks are spread across a large pool. We need pooling mechanisms to create that same kind of avenue for people who do not have employment based insurance and this is the secret behind the insurance exchanges or gateways, and we will hear more today about how Massachusetts put that in place as well.

The bills have different ways of getting to them, but they all in essence in the end allow the states to have exchanges or gateways or the national government to create a national exchange or gateway, so different avenues to create these pools so that people have access.

Affordability credits would be granted people lower down on the income scale to help them afford the coverage and of course a lot of debate now is how far up the income scale you go for that.

We have in addition emerging from the Senate Finance Committee the notion of also supplying tax credits directly to small businesses to help them afford the coverage. This is in order to help them sustain another aspect of the bills which is a mandate leased in the house side, a mandate on employers to provide coverage, stretching that employment based safety net.

We have a number of insurance market reforms that have to take place, otherwise people are going to be screened out of insurance, the leading one of course is the fact that if you are buying coverage on an individual market, you could be subject to pre-existing condition restrictions which means if you have diabetes, an insurer could happily sell you a policy to cover everything but your diabetes.

Obviously that is a non-starter if you are going to try to get everybody insured and in a sense that you are going to have somebody actively involved in helping to manage their health care costs and this is just some more about the insurance market reforms.

Big question mark of course is the role of the public plan; the public plan is also seen by those who are in favor of it as another way of insuring access for people. In the house bill, as you know, there is a national public plan, the senate health bill talked about community insurance plans, and the

senate finance committee when it comes up with its bill finally seems to be coalescing around the notion of co-ops.

But again, it being perceived as there being the need for another avenue, not just for access but also to enact delivery system reforms, and I will say more about that in a moment.

I mentioned the employer and importantly the individual mandates, another very important focus of the bill is to make sure that people are offered coverage and that they take it up. There seems to have been sort of a growing consensus that the whole system is not going to work unless everybody is in the pool. The costs have to be spread across everybody, the young and the elderly, the healthy and the sick, etc, that is how we will keep coverage more affordable over time for everybody.

We obviously have a lot of problems in our U.S. health care delivery system, side by side, with many, many strengths. To a large degree, health care reform will be about delivery system reform, and since 75-percent of our spending is tied up with chronic disease reform, a large part of the delivery system reform will be figuring out a way to deliver chronic disease treatment and care much more effectively.

So, what do people have in mind for doing that? In the house bill, broad authority would be handed to the secretary of health and human services to launch a lot of tests, delivery

system innovations like accountable care organizations, we will perhaps hear more about that in a few moments, medical home, value based purchasing, etc, different ways of paying providers as Ed said, not to just pay on a piecework basis but to pay people to really nudge them toward providing a whole system of care that works to expand people's health.

You have heard some discussion about MedPAC on steroids, which is another aspect of basically reinforcing new payment delivery systems. I will not spend much time on that because I am out of time and then just finally a couple of other key issues on the work force as Ed said, we are not going to have access to care unless there are the right people in the right place at the right time to care for people.

So lots of emphasis in the bills on more training of primary care doctors, expanding the pipeline of people going into health professions, making better use of team focused care with others delivering primary care, nurses, physicians' assistants, and so on.

Just finally, of course, the major work in progress still remains, finding the revenues and the savings, putting that package together to pay for this, and you know that on the senate finance committee side this is still a work in progress, lots of savings being anticipated coming out of Medicare and Medicaid to help finance the costs.

What is ahead? Well, with that we take our hats off to the immortal Yogi Berra who said once that prediction is very hard, especially when it involves the future. So, I am going to turn this over to the rest of my distinguished panelists who have a better crystal ball than I do about predicting where all of this will come out. Thank you, Ed. [Applause]

ED HOWARD: Thanks very much, Susan. By the way, the Robert Wood Johnson Foundation has an excellent website called, appropriately enough, healthreform.org, where you will find a lot of background material and the Kaiser Family Foundation has a nice side by side comparison that they update fairly frequently on the major provisions in the bills as they are emerging and I commend that to you as well.

Now we are going to turn to Dr. Nancy Dickey, who is president of the Texas A&M Health Science Center. She is vice chancellor of the Texas A&M System. She is a family doc by background, a former American Medical Association president. She is chair-elect of the academic health centers association, and the part I am most proud of, she is a member of the Alliance for Health Reform board of directors.

She is in a unique position to talk about how to meet America's need for primary care practitioners and how well the reform initiatives address that need, because she is doing that every day. Nancy, thanks so much for coming up.

NANCY DICKEY: Thanks, Ed, I am delighted to be here and as a member of the Alliance board, let me give you welcome from the board. As Ed said, I have a number of perspectives to look at the issue of primary care including that I established and ran a family medicine training program and was an interim dean of a medical school for a time, perhaps the one conclusion I can draw is this may be one of the biggest challenges ahead of us, so let us talk a little bit specifically about primary care.

Currently, there is widespread belief and a good bit of data that says we have inadequate numbers of primary care providers, however it is that you may want to slice and dice them. This is the list of the groups we tend to look at as primary care providers.

Interestingly enough, you all look too young, but if any of you are around from the 90s, we had lots of people who wanted to be primary care, I talked to clinician friends who said I am a primary care anesthesiologist or a primary care dermatologist [laughter], so perhaps self reform Susan will again give primary care some stature and will have people fighting to get in instead of scrambling to get out.

But the generally accepted group is this group that is here in front of you. Unfortunately some of the same things that have happened to primary care physicians where larger

numbers of our graduating medical students have chosen to go into subspecialty care rather than family medicine, general internal medicine or general pediatrics, has also begun to take a toll on a group that we have thought would be part of the solution, that is nurse practitioners and physician assistants.

We discovered that they, just like physicians, find themselves drawn to metropolitan areas and subspecialty practices for many of the same reasons, there is a pay differential, there is often a work distribution differential, that is how hard they work, how long the hours are, and so we will be talking about all of these groups as we talk about how to increase the numbers of primary care.

The other issue I could not fail to address is with the profound nursing shortage, instead of being able to see nurse practitioners as a big piece of the solution, we will find more and more call on nurse practitioners to be faculty members, to again meet some of the needs in subspecialties.

As we look at recruiting into primary care, I would say that there are a number of issues I am going to talk to you about and then towards the end I will talk to you about which ones are addressed in the bills that are in front of you. What this slide says is simply creating more positions to train more primary care providers is not the solution.

As you can see from looking at this, there are unfilled positions in every one of the primary care areas, some of them 10-percent like family medicine, some of them only 4- or 5-percent, but the reality is there are plenty of positions if more graduates of medical school wanted to go into primary care. The problem is they do not and we will talk about the reasons why.

In fact, the story is even perhaps more challenging than what this slide would indicate to you because while there are still for example 6-percent of family medicine slots that do not have anybody training in them, there are a substantial number of foreign medical graduates, international medical graduates, who come in to fill primary care slots, so U.S. physicians occupy an even smaller portion than the percentages you see in front of you.

So, why don't people want to go into primary care? You have to answer that question obviously in order to decide what to put into the bill to try to attract people into primary care. The first issue, as you have already heard referenced by Susan, is money.

Now, I grew up on a farm in a small town and those looked like pretty decent incomes to me, even the ones on the smaller end of the scale, but you have to keep in mind that we don't let very many dumb people into medical school.

So they say now you want me to invest the same amount of time to become a radiologist or a family doc, but over the course of my career there are millions of dollars differential in terms of what I am going to have to retire on or buy a retirement home some place and so income is a part of it.

I actually had a young lady who came out and spent time with me while I was in practice. She was in medical school, thought she wanted to be a family doc, and she looked at me with great seriousness and said but Dr. Dickey, if I do that, will I ever be able to buy a house or a car? [Laughter] Yes, I think so.

But the difference of course is that if I have the choice between $600,000 a year and $200,000 a year, for the same amount of education and actually probably less work hours down here than up here, then an awful lot of people wisely say why wouldn't I want to go into dermatology instead of family medicine?

There are of course other reasons. It is not just about the money. When we get people in the medical school, we often don't mentor them. We don't tell them that family medicine or general internal medicine is a good place to go. In fact, many times today we still hear students told that they are too smart to be just a family physician.

Actually I was handing out scholarships the other day and asking a young lady about who in her family was a physician, she said well, my dad is. He is just a family physician. I almost took the check back. [Laughter] There is no J in front of that FP.

But, that is the kind of mentoring we provide. Again, they want to go places they are going to be highly respected, they get that kind of encouragement into subspecialty care. They watch hospitals spend big dollars in order to recruit the neurosurgeon or the interventional radiologist, but they go to primary care settings and find that often they don't have the investment in the infrastructure to allow them to do information technology. It sends a subtle non-verbal message.

Medical school recruitment, we have good data that says that young men and women who come from small towns are more likely to go into primary care and more likely to go into rural primary care and yet the numbers of people going into medical school, being accepted into medical school, continue to increasingly represent metropolitan areas. That is where they get access to education that gives them the high MCATs and the high GPAs and so forth.

Practice demands, it is hard work, long hours oftentimes, and additional challenges for rural and inner city

areas that are difficult to meet as well. So, you wonder why any of us would actually choose to go into family medicine.

But there are things that we can do. We can enhance medical school recruitment. There is not in any of the bills but we could talk about giving bonuses to schools that either have higher ethnic variability or bring in students from rural areas or non-urban areas. We could do better faculty mentoring. Though the numbers aren't adequate, there are still lots of good family docs, general internists, out there if we could talk them into telling their story more often.

The things that are in the bill and we will talk a little more about are loan pay backs. Many times when you are facing the end of these eons of training, what you want to do is be able to buy a house and pay back your loans, as Deborah and I were talking about earlier. So, if we give you loan pay back, that $200,000 a year for primary care may look more appealing than if you have to pay back $150,000 in loans, buy a house and know that you are going to be making a third the income as your colleagues happen to be.

We are going to talk about opportunities for training and certainly we want to be sure that there are opportunities for anybody who wants to train in primary care, but as the second slide showed you there are plenty of vacancies today, despite the fact that we have closed down a number of training

programs because they couldn't fill their slots with students that wanted to go into primary care. So, the bill again creates lots of opportunities for additional training.

The other thing the bill does, it talks about the medical home. When we started having conversations about this in the Academy of Family Physicians, the Academy of Pediatrics, and general internal medicine, many of us thought that is what we had been doing most of our lives, providing coordination of care, trying to help patients decide when they needed a specialist and which specialist they needed.

But the reality is that we have moved away from that in a lot of health care today, so if patients self-refer to specialists, they may have half a dozen doctors treating them simultaneously, often with prescriptions that don't always fit well together.

So, what these bills do is recognizes the potential need to change the way we deliver primary care and they called it the medical home. Patient centered medical home is an approach to providing comprehensive care for children, youth and adults, that is a definition agreed to by pediatrics, internal medicine and family medicine, and they have been very involved in trying to be sure this definition is represented in the bill language.

A couple of interesting quotes to suggest this isn't a new thought concept. William Osler from 100 years ago says you treat the disease the patient has rather than the, let me just read it because I'm doing a bad job, right? [Laughter] "The good physician treats the disease. The great physician treats the patient who has the disease." And primary care often is seen as the group that perhaps embraces that whole thing.

Giving us some financial incentives to create medical homes, to coordinate the care, and then hopefully to entice our subspecialty colleagues to participate in that coordination rather than seen to be separate from that, in fact could move us in the right direction.

So, we talked about why people don't go into primary care, the fact that there certainly aren't enough there and you are going to hear from some people that Massachusetts discovered that, let's talk about what the bill does in order to address some of these needs.

Loan repayment, it increases the amount of loans that would be paid back if you go into primary care areas up to $50,000 in some cases, and that is about half what the average medical student comes out with in loans, and more than they can currently get. They also, if they go into primary care, can get a lower interest rate.

Expanded national health service corp, which is another way to pay back your medical school loans and there is good data, again, that if we can entice these young men and women into the national health service corp, which is primary care, that a substantial number of them will stay in primary care, even though they were considering going into the subspecialty arena when they finished their pay back. They decided that maybe what they are doing is kind of fun.

Payment, it is addressed in several different sections in the bill, most of the time tied to moving Medicaid payment up to 100-percent of what Medicare pays, since many of the physicians I work with think Medicaid payment is not very good, that will give you a clue how low primary care payments are, that we think this is a step up. It addresses increasing Medicaid payments, Medicare payments, and the possibility of needing an update for Medicare payments, separating the primary care and the subspecialty groups.

It talks about training. It talks about the fact that primary care docs tend not to practice in hospitals, yet most of our graduate medical education, most of the time we spend training is in hospitals, so maybe we should move the training out so it looks more like the practice you will do when you are actually out earning a living.

The problem is the money to support graduate medical education specialty training is tied to hospitals. So, what this bill does is actually ties payment to the opportunity for doing ambulatory training. If you see what it is like and you enjoy it, you will be more likely then to continue in that arena but we have to make sure the dollars follow the residents.

Transition of unfilled primary care positions that is if there are positions, if you will go back to that first slide you will remember there are 10-percent or so of subspecialty positions that don't fill. This bill would move those positions, funded positions, into primary care arenas.

As I said to you early on, that won't do any good unless you convince more of my graduates to go into primary care. It is not that there aren't enough slots right now. There aren't enough people willing to go into those slots so we have to address those other issues before transition of unfilled position is going to do any good.

I find very interesting there are some pilot projects for training interdisciplinary. We tend to train in silos. Doctors train over here, nurses over here, pharmacists back there some place, even though when we get out in practice we all have to work as a team and the concept that this team is going to be more efficient than any one of us individually is a

very interesting concept, but one that we don't have any money to train toward today.

Medical homes, and then many of the same things I talked about for physicians are included for nurses, dentists, and public health. There are some special funding pilot programs for accountable care organizations that I think you are going to hear more about, extension of the geographic floor for work that is they will pay more if you go to a rural area. That is a huge step forward by the way.

Up until now, most payments were tied to what they perceived to be the cost of living and so if you were in a rural area, the assumption was it cost you less to practice there and they actually paid you less to go to a rural area rather than the same or more, despite the fact that those are some of the most challenging work places that exist.

I added in here comparative effectiveness research because I believe as we do the research about what the best quality of care for the best dime is, we will discover over and over again as Barbara Starfield and others have that starting at primary care is the best bang for your buck.

So I can't think of anything that is going to advance primary care more than us actually investing in what is the best, most efficient way to deliver care with the smallest number of dollars as opposed to whether we can prove that the

new pill is better than the sugar pill rather than the existing pill, which is what we do most of our research on today.

Bibliography for some of the sources, but many of the best sources are in your packet, and all of these will be available on the website. The reality is we need primary care to make this work, we have got an awful lot of things that need to be changed in the existing system, not the least of which is the way that we pay folks to make that happen.

ED HOWARD: Thank you, Nancy. [Applause] Now, you have heard an overview of the national situation in general, and of the situation with respect to primary care, and its associated issues, I'm going to turn now to sort of a case study of how this works out in a specific place, that is to say the commonwealth of Massachusetts, and we have asked our next two speakers to address, first a private sector approach and then a public sector approach for dealing with the question of access.

And, that means we are going to hear next from Deborah Devaux. Deborah is the executive director of community transformation at Blue Cross/Blue Shield of Massachusetts. One aspect of her responsibility there is this dramatic new initiative on payment reform that was recently launched by Blue Cross/Blue Shield.

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The CEO of that corporation, I was telling Deborah before we started, is a fellow named Cleve Killingsworth. He has been describing this initiative at meetings of a commission that he served on and that I have attended meetings of, and it is a fascinating experiment.

While the congressional negotiators struggle with how to reshape health system payment for care in a way that encourages high quality and cost effectiveness, Deborah and her colleagues in Massachusetts are actually starting to do it, so we thought we would ask her to try to explain a little bit of how it came to be and how it is working out. Deb thanks for coming here.

DEBORAH DEVAUX: Thank you so much. As my role will be to talk about how payment can help support access, so I will be eager to hear your questions in how this relates to your work.

The vision in Massachusetts, I think similar to the vision of our country, is to create a system that all have access to and that is effective, safe and affordable. The challenge for the plans is that when physicians and hospitals and patients look at how we pay for services, what they could say is we actually do not pay for any of those things right now.

We are not paying physicians and hospitals differently if the care is safer or more effective. We are not recognizing

them if they manage to produce more affordable care and so we as health plans, and Blue Cross of Massachusetts is a payer, feels very strongly that we need to play our role in changing that and let's start to pay for the things that we all want, safe, effective, affordable care.

So as you will hear from Sharon in a moment, our state took the first steps to try to provide insurance coverage to all the citizens in our state and we have made some good progress on that. But we immediately, once we made access to coverage available, we immediately bumped into the issue that care was still not affordable, was not the safest care that we think that we can provide as a system, and was not necessarily the most effective, and we have grave concerns about losing the broad coverage if we can't create affordable care.

And so what we have begun to do is to offer an alternative contract to the providers that are in our network in the state of Massachusetts. It is not required for participating in Blue Cross, but what we are able to say to providers is if you are prepared to accept accountability for cost of care, effectiveness of care, safety of care, you will be recognized with greater revenue if you can produce that, so the basic structure of the relationship is that we have created long term partnerships.

Of course in health care, long term is five years, but the idea being that one of the barriers to physicians and hospitals being able to restructure the way they do things is that they live year to year not knowing what their payment is going to look like. Most of the payers make decisions about how they are going to structure payment on a year to year basis.

And what we have done is to say to providers who are willing to commit to a long term five year contract that we will guarantee their payment levels over that five years, which gives them the opportunity to think a lot more creatively about how they want to recognize the efforts within their system to change care, and the contract does for both outpatient care and inpatient care pay differently according to the results of that care, rather than just paying for each service that is provided.

So, this chart shows you the basic structure of the contract. The blue bar below the line establishes a budget per patient, a global payment that the providers pay regardless of how many services they provide. They are no longer incented to do the MRI or to provide a service unless that service is going to create the most effective outcome for the patient, and the provider is freed up to offer some services that might not be recognized or paid for in a traditional fee for service model,

so what we feel the global payment does is to get the insurer really out of the way of doing mother may I utilization review.

Is that admission needed? That decision is left in the hands of the providers and if the admission to the hospital isn't needed and the providers can avoid the admission by offering services in a different way, they are recognized for that.

The second component of the five year contract is there is a guaranteed inflationary increase each year but this is where the benefits to those who are purchasing the care, the employers or the individual member is realized, because that increase, that year to year increase, is lower than the increase that we are experiencing in the rest of the system.

So, if the rest of the system is producing a 9- to 11-percent increase, the increase annually in these contracts is much closer to CPI, much closer to the level of inflation that we are experiencing for other services in our economy.

And then the final component which is the component we are most excited about, is recognizing quality and so for us, putting significant dollars behind recognizing those providers who offer better quality of services is really the most important part of this contract and I will show you the performance measures specifically in one minute, but one of the key questions we often get for those that lived through the

capitation models of the 90s is haven't we don't this before and why is the alternative contract different?

And we certainly have experimented with capitation previously in this country and with some disastrous results for certain physicians and hospitals. We feel there are a number of differences that relate to how the budget is constructed and the fact that we are now able to better predict the expected health care costs of members than we were 15 or 20 years ago.

However, we do feel that we need to continue to look very carefully at how these budgets are constructed because there are still things to be learned and we obviously are protecting the providers from unexpected insurance risks. So the cost of a neonatal baby who needs neonatal care or someone in a car accident, those things that aren't subject to better management, they are insurance problems. So, we feel that the global payment that can be done in 2009 is a different one and is subject to a better predictive science.

I am not sure if you can see these well on the screen, but we have established performance measures that are nationally accepted, well recognized measures of care. These are not measures that were uniquely developed by Blue Cross, partially because we feel that providers have developed measures that they think are important and that can be measured

in a valid way, partially because we want these measures to be able to be adopted by other payers.

So we recognize that any single plan, you know, Blue Cross of Massachusetts covers about 30- to 35-percent of the people in our commonwealth and we know that even if all of our members were in this arrangement that it is very hard for a physician to completely restructure their practice for 30, 35, even 50-percent of their patients.

So we want to collaborate with other plans whether that is Medicaid, Medicare, the other commercial insurance plans in our geography, to adopt similar measures so that the physicians and hospitals can perform across a common set of measures for all the plans and we think that is going to be the best way to really move the dial, not to have different measures for different plans and cause the physicians and hospitals to be trying to move their performance across a broad variety of measures, but to limit that pool and so these are measures both for the hospital and for outpatient care that fundamentally address the structure, the process and the outcomes of care.

The other thing we thought was exciting about these measures is that we initially provided the same weight financially in our incentive payments for all of the measures because we felt that there wasn't any science around how to weight those measures differently, and when we took this

construct out to the providers, the physicians said to us, well don't you care a lot more about the outcomes than you do about the structure and the process?

Don't you care a lot more whether a patient has gotten a hospital acquired infection that was avoidable or a complication after surgery that was avoidable, or that their blood sugars are at the right level, than you do about some of the clinical process measures, and we said sure, but we know those are harder to achieve and the physicians said well, then, why don't you triple weight those?

In other words, weight those measures so that if they are achieved you get three times, pay three times more than those measures that are structure and process and that made a lot of sense to us because like many other people I bought an exercise bike. That is the structure.

I may have used my exercise bike but unless I actually lose weight, lower my blood pressure, and I am in better physical health, buying a bike really is not enough and that is what the physicians were saying to us is even if we put in the right structure and the right process, if the outcome for the patient isn't achieved, then there is a problem and so we have triple weighted the outcome measures.

And then finally, we have created a scale so that those physicians who achieve the highest rates of performance that

are possible – so in other words, we are not setting the highest gates at a level that is not achievable - will be paid significantly more and our belief is that with this type of payment system, the incentives for the delivery system to restructure because the only reason for payment reform is to allow providers to restructure care, will enable some of these fundamental problems and access including primary care to be reimbursed appropriately, recognized appropriately in terms of quality and efficiency, and can fundamentally help solve some of the problems of access.

ED HOWARD: Thanks very much, Deborah. [Applause] And as I said, we are going to turn now to a look at what government in Massachusetts and the people who are subjected to it have done about access questions and we are going to hear from Sharon Long. Sharon is a senior fellow at the Urban Institute Health Policy Center here in town.

She is a health economist of national reputation and she directs the Urban Institute's evaluation of the Massachusetts Reform Initiative as well as the Massachusetts Household Insurance Survey for the state government itself. She is also doing evaluation work on a number of other state reform efforts so she has a perspective that is uniquely useful to try and take a look at the reform measures in Massachusetts.

There is a *Health Affairs* article, the gold standard, that Sharon has written on Massachusetts and it is in your packets. There is in fact an electronic version available through our website at Health Affairs that updates that paper and I commend it to you, and Sharon I am very pleased to have you with us and tell us a little bit about what is going on in Massachusetts on the public side.

SHARON LONG: Thank you. So my job is to give you an update on a real world health reform example and let me start by acknowledging the funders for this work, Blue Cross/Blue Shield of Massachusetts Foundation, the Commonwealth Fund, and Robert Wood Johnson Foundation. And actually, I have changed my slides a little bit.

I took one of Susan's slides as I want to kind of give an update on Massachusetts relative to the primary goals of health reform that she mentioned. As you will remember, it was to improve access to care, cover the uninsured, and bend the health care cost curve.

So when we look at Massachusetts, and I'll go into more detail in this as I go through the slides, Massachusetts has significantly improved access to care and as it wasn't near universal health insurance coverage in fall 2008. This was before implementing all of the elements of health reform so before the minimum credible coverage standards were fully

implemented and before small businesses could buy into the Commonwealth Choice programs, so significant gains there.

In addition, this was before what some are calling round two of health reform in Massachusetts, which Deb mentioned, which is the state made the decision to address the expansion in coverage and improvement in access to care first and then to turn to health care costs. That's where the state is now, really just beginning to address health care costs so substantial progress for the first two goals but just starting on the third.

The work that I'm reporting on today is based on a survey in Massachusetts. We did a baseline survey in fall 2006. That's our pre-reform world and then we've done follow up surveys in fall 2007 and fall 2008 and we're working on funding for fall 2009.

So we're looking at how insurance coverage, accessing use, and affordability have changed as health reform has been implemented in the state. I should note one of the limitations here is that we're looking at changes over time. So we capture health reform and other changes over the same time period. So in this world, we capture the impacts of the recession and the impacts of rising health care costs as well.

So it's not a pure measure of the impacts of health reform but what I would caution here is that those two effects,

the recession and the rising health care costs would tend to dampen the effects of health care reform. So we're probably underestimating what health reform would have bought if the economy had stayed stable and health costs had stayed stable.

So with that quick overview let me turn to the findings. Let's start by looking at the impacts of health reform on insurance coverage in the state. This slide shows insurance coverage in fall 2006, which is the yellow, in fall 2007, which is the blue, and fall 2008, which is the purple. The first set of bars are the overall population in the state.

The second set is lower income adults and the third set is higher income adults. We're defining lower income as adults with income less than 300-percent of poverty. That's the cut-off point for eligibility for Massachusetts' subsidized insurance program, the Com Care program.

So as you can see, there were significant increases in health insurance coverage across the overall population as well as for the lower income and the higher income group. So the overall group, insurance coverage in fall 2008 was at 96-percent, so pretty close to near universal coverage. This compares to about 80-percent in other states in the U.S., so well above what we're seeing in other states.

Not surprisingly given the scope of changes in Massachusetts, which were targeted toward the low-income

population, most of the gains in insurance coverage were among low-income adults. There you can see a gain from 76-percent coverage in fall of 2006 to 92-percent coverage in fall of 2008, so a substantial gain over the three years of health insurance reform.

I should note here, I'm not showing it in the slide but the increase in coverage in the state is both gains in public coverage and gains in employer-sponsored insurance coverage. So we don't see crowd-out of employer-sponsored coverage in Massachusetts with the gains in health insurance coverage and would attribute this to the individual mandate that we're seeing actually an increase take up in the SI coverage in the state.

In addition to seeing gains in insurance at a point in time, we also see gains in continuity of coverage. So looking at this slide, which shows people who had coverage for the full 12 months, you can see substantial gains there as well so less cycling on and off of insurance coverage, which should translate into our continuity of coverage over time. So when we turn to look at accessing use. You can see that the gains on insurance coverage have translated into gains on accessing use in the state.

The first set of bars are looking at having a usual source of care. So this is people reporting that they have a

provider that they see when they're sick or when they need advice about their health. So this is the measure of connection to the health care system and of continuity of care over time. As you can see, we see an increase in that under health reform.

The next two sets of bars are looking at doctor visits. So any doctor visit and multiple doctor visits and again, you see a gain in access there. More people are seeing doctors and more people are having multiple doctor visits over time.

To place these in context: 83-percent of adults in the U.S. have a usual source of care that compares to the 92-percent in Massachusetts in terms of doctor visits, 78-percent of adults in the U.S. have a doctor visit and it's 85-percent in Massachusetts. So we see better access to care in Massachusetts and gains in access to care under health reform in the state.

One limitation of the survey that we've done is we can't identify people who gained insurance coverage because of health reform. All we have are three cross-sectional pictures. What we wanted to know was whether were the gains in access just from obtaining insurance coverage or were there gains in access for other people in the state since there were changes in minimum credible standards for insurance coverage.

So what we've done is look at people who had employer-sponsored coverage for the full year and looked at those over

time. What we see with that population is gains in access to care for that group as well. So it looks like that Massachusetts reform effort both expanded coverage and improved what counts as coverage in the state so that there are gains on both front.

Consistent with that, we also see gains by income level. Most of the gains in access are among the low-income population. That's the population that gain the most in insurance coverage but we also see gains in access among higher-income adults. There, one of the areas you'll see the strongest gains is access to preventive care. People are more likely to get preventative care.

That's one of the changes with minimum credible coverage where preventive care is covered before the deductible applies. So if the gains in access are more broad-based than just those who gained insurance coverage.

Another way of looking at access to care is to look at unmet need for care. This slide is reporting on people reporting unmet need for care over the past year for any reason. We looked at unmet need for doctor care, specialist care, medical test treatment, and follow-up care, prescription drugs, and dental care.

I should note here that although these looked high in levels of unmet need, if we look within a survey that has data

for other states, Massachusetts tends to be lower than other states. So in the context, Massachusetts has lower levels of unmet need but still does have unmet need among its population.

So here what you see is strong reductions in unmet need in fall 2007. So in the first year under reform, strong reductions and then some offsets of that in fall 2008 and so a bit of a paradox. We saw increases in access to care, more people going to the doctor, more people with more doctor visits but we're seeing more reported unmet need for care.

So it's clear that there was a push up in demand for care in the state and then people had a harder time getting care. If you looked at the sources of unmet need on the far right corner, it's specialist care and medical test and follow up care where we're seeing that offset in unmet need as people are trying to get care.

So what it shows is that as people were trying to get care under health reform in Massachusetts, they were running up against the capacity of the provider supply and that this was an issue prior to reform that has become more of an issue as more people have care in the state.

Because we'd seen some indication of this year, we added a question to the survey this year to gather more information about difficulties obtaining care. So I can look at this in 2008 but I can't tell you how this has changed over

time but if you look on the far right hand bar, one in five adults in Massachusetts in 2008 reported difficulty getting care either because of a provider was not accepting new patients or a provider was not accepting patients with their type of insurance coverage, so some difficulty finding providers.

This was reported for both primary care and specialty care, so it's not purely a specialty care phenomenon. It is more common among lower income adults and adults with public coverage than higher income adults or adults with private coverage. Part of it may reflect the expansion in coverage in Massachusetts.

A large part of it is within the public programs and the public programs were within four plans. So it was a fairly narrow provider network that had a very rapid increase in coverage but nevertheless, we are seeing some difficulties getting access to care in the state.

Then the next issue we looked at was affordability of care and health care costs in Massachusetts are going up as they are in the rest of the country. That predates reform and is not a function of reform but what we're starting to see is some effects of that on reform.

So here, as in the access measures, we saw gains in affordability in the first year under health reform by fall

2007 and then by fall 2008, some loss of ground on those measures so that we no longer see the significant gains or significant improvements in affordability over time.

So based on these findings, it does look like the trends and rising health care costs in the state are starting to undermine some of the early gains in affordability under health reform.

Since part of what Massachusetts was able to achieve was bringing together disparate stakeholders to come together and agree on a reform initiative, everybody gave a little bit. Everybody got a little bit. That support was strong in 2006 when reform passed. That reform has remained strong despite much press about the cost of reform and the unexpected higher levels of enrollment relative to the estimates that were in place before.

Support has remained strong across the population. When we look within subgroups, when we look at higher and lower income, it remains strong. When we look by gender, men and women supportive, different ages are supportive, different regions of the state are supportive. So it’s amazing the uniform across the state that support persists for the health reform initiative.

So let me just recap with a broad overview of what we know as of fall 2008. There were significant gains in insurance

coverage in the state. There's no evidence that private coverage has been crowded out by the gains in public coverage. There was significant gains in access to care particularly in the last year as people gained coverage and kept coverage for the full year. There were some significant improvements in affordability.

Despite these successes, there were some indications of problems over the last year. There's some loss of the early gains in affordability as health care costs have continued to rise in the state and limits on provider supply with the increased demand of care have created barriers to care for some people in the state.

Then finally, as I mentioned earlier and as Deb mentioned, health care costs is really round two of health care reform in the state. Massachusetts is just beginning to really address health care costs. It's clear that the sustainability of health reform in the state will really be a function of their ability to bend that cost curve just as it will be at the national level. Thank you [applause].

ED HOWARD: Great. Thank you very much. Thank you Sharon. We've come to the part of the program where you get a chance to ask questions. As I say, there are microphones that you can go to, to ask them. If you fill out a written question on that green card and hold it up, someone will bring it

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forward. Let me just start, if I can Sharon, with one of the points that you were making about what the reforms are starting to do to access even as people are having more frequent doctor appointments.

There is, in the materials, a survey that was taken in a number of cities that seems to say that folks in Boston were having more of a difficulty over time than those in most other places in the country in getting an appointment to see a physician. Tell us what you think of that and whether it's something we have to watch out as we work on access more generally.

SHARON LONG: Well I think there's actually other evidence from this Massachusetts Medical Association that is consistent with that. There has been kind of more demand for care and as more demand for care, longer waits for care. If you look at kind of the timing of the increase in coverage in the state, it's clear enrollment happened faster than the state expected. I mean it's a good thing people got coverage but it happened very quickly. It happened within a relatively narrow set of networks.

So there wasn't a strong increase in demand. What we think will happen over time, we don't have the data yet, would be that some of that pent up demand will be eased as people get care and they get follow-up care. So the demand should be

mitigated as people continue to have coverage. What we're seeing is people have coverage for the full year. It's not just cycling in and out. So as that happens, we'd expect some pushback against that high level demand.

ED HOWARD: Susan?

SUSAN DENTZER: And I think this underscores why delivery system reform is such an important component of overall reform. We all know the phrase you get what you pay for. What we get today is doctors get paid if you come into the office and they have a visit with you. In the fee-for-service system, they don't get paid if you don't come in, which is why your doctor is likely to recommend that you come in to see him or her.

If you look at systems that have moved away from fee-for-service like Kaiser Permanente, a capitated system, we published a study several months ago that looked at what happened when Kaiser put in place secure email capability between patients and their physicians and lots of other interventions so that you didn't necessarily have to come in to see your physician.

What happened? Visits dropped by 25-percent. People, it turns out, don't really want to get in the car and drive three hours to see their doctor if they don't have to, Nancy. I think you would concur. The delivery system has, in a way, been

frozen around the way we pay it. So as we think of new ways to pay the system, the system will break up these frozen blocks of turgidity and do things like use email and do other kinds of things that will make them possible to have more encounters with individual patients and free up some of the capacity to be used in those directions as opposed to just in the old fashioned visit.

ED HOWARD: Alright. We have someone at the microphone. If you would identify yourself and let me just ask all of you who come to a microphone to be as brief as you can to allow us to get to as many questions as we possibly can. Yes sir?

AL MILIKAN: Al Milikan, AM Media. How do each of you see abortion access and coverage affecting overall health reform?

ED HOWARD: Wow, you can see everyone's leaping to answer that question and if we have no takers, I'm going to have to whiff on it. Nancy, do you want to take a crack at that?

NANCY DICKEY: I guess I don't think it's going to have, I think that it's another set of services that some doctors or some providers will perform and some will not. Some payers will pay for it and some will not. I suspect that it's just not an issue that's going to substantially tip this one way or the other although it does have the potential, I guess,

to elicit enough polarization that it could perhaps be used to either push in favor or push against that reform but I would think that we should look at it as a service as opposed to something that ought to define whether this wins or loses.

ED HOWARD: Okay. Yes sir?

DAVID RABIN: David Rabin, Georgetown Medical School. Massachusetts, to begin with, is in a far more favorable state in terms of medical resources, both primary care physicians in terms of rates and specialists and a smaller portion of people who are uncovered, substantial community health centers. We're going to be an analogous reform through Congress, I'd like you to address the workforce issue because it appears, on the two years, that that's already a serious problem and a very favorable, probably among the most favorable, situation we have in the nation.

DEBORAH DEVAUX: Yes. Well one comment, I agree with you that there's some aspects of Massachusetts that are very favorable. We had a lower uninsurance rate than other parts of the country and as you point out, there's strong academic resources for medical education in Massachusetts. However, there's also some big challenges. For example, the cost of living in Massachusetts and the ability to maintain a lifestyle in Massachusetts and, as Nancy was saying, as a practicing physician there, earn enough to live there.

So we feel that, while there may be aspects of the experience in Massachusetts that are easier to achieve in our state, there are probably some issues in other states that are going in the other direction but I think what is going to be similar is that creating access to coverage will immediately bump into the significant problem of affordability and that fundamentally, although that affordability issues may vary a bit between states.

I do think we all have that issue that the costs of care are growing more rapidly than what we can afford to cover. So I think the work around how to restructure the care so that it's more affordable may be more similar across the states. Does that address your question?

ED HOWARD: Sir, if you're going to speak, you should speak from the microphone, if you would please.

DAVID RABIN: I sense from the preliminary data is the issue of actual access to physicians. The longer more physicians are not taking, particularly apparently lower income individuals, therefore a greater discrimination in terms of who you see and apparently some backlog in terms of people able to get access to care that they wish.

SHARON LONG: I think part of what Massachusetts is hoping to do with their health cost reform is to address some of those issues to provide the incentive to see the patients in

primary care settings and to make some of the adjustments that Susan was talking about that it's more effective care delivery. I think the other point I would make among Deb's is health care costs are higher in Massachusetts than the rest of the country and are rising faster in Massachusetts. So that piece is not kind of the positive picture in Massachusetts that other aspects are.

ED HOWARD: Susan?

SUSAN DENTZER: And just to underscore what Nancy said earlier, the key issue really is primary care, short [inaudible] primary care. She mentioned Barbara Starfield's where it's very clear from Barbara's and others' work that primary care is highly correlated with the most cost effective, highest quality care. So if you've got access to a primary care physician or primary care providers, you're going to have better care overall. So that we know.

Now we have this crazy system, as Nancy said, go back to you get what you pay for. So we take the people in the system who provide the best, most reliable high quality care and we pay them the least. What's wrong with this picture? How did the system get this way?

Then we take the people for whom frankly specialists, many of them are very wonderful people. If you know much about the evidence base in medicine, the evidence base for a lot of

specialty medicine is pretty thin. So we take the people who are applying the things that we have the least amount of evidence about and we pay them the most. What's wrong with that picture?

So we're going to have to undergo this long-term process of equilibrating the payments so that we're paying more for the stuff that we have a better sense provides higher quality, more affordable care, and less for everything else. If we all think this is going to be easy, just mention this proposition to your average highly paid medical specialist, it's going to be quite a war but over time, we think we can make some progress but it's why these overall gradual payment system reforms are going to be so important.

NANCY DICKEY: I do think it's worth adding though if you go back to the 90s when managed care capitation briefly held sway, it will be every bit as painful as Susan and the others have said but it may not take this long as we think it will.

During the '90s, a decade of reform in terms of how we paid for care, we created tremendous numbers of new primary care training programs, filled them probably the only time in my history, with the top students in the classes. It was the place to be because we thought we were going to change the way we paid for care and what we valued in this country.

So if, in fact, reform can begin to show that there's A, that it's going to exist for a while and not just a couple of years and that we're going to shift what we pay for, I think that we will find many graduates who begin to look at primary care much faster perhaps than we had originally anticipated. The 90s is the evidence I'd have to look at.

ED HOWARD: Okay. Yes, Gary?

GARY CHRISTOPHERSON: Gary Christopherson, former VA, DOD, CMS, Congress. In the 1970s – I want to challenge how we're approaching this – in the 1970s, we built an inner city, public-private, comprehensive health system in one of the larger communities in the United States and the key is we learned a lot from it about what you need to actually produce healthy people and healthy communities. The approach to health reform to date has been slices. Some good slices, necessary like primary care, health insurance, this kind of thing.

Speak to me a little bit about what we would really need, what's missing from the health reform discussion about if you really want to build healthy communities and make that happen.

ED HOWARD: Healthy communities?

SUSAN DENTZER: Well I think most health policy experts and public health experts in particular would agree that there isn't a whole lot of emphasis on public health in the reform

bills. Now there's some. There's more payment for preventative care, etc., etc. but we look at some of the situations that we face now, for example, the obesity crisis and we know we're going to need to bring a whole lot more to bear on this problems than just insurance coverage.

I think that the whole issue of the so-called social and economic determinants of health, that is to say your health status is, to a large degree, going to be determined not at all by your health care access and the treatment you get in the health care delivery system is going to be determined more by fundamental factors like your income level, did you grow up next to a toxic waste dump or not, all those other kinds of things. That's going to be a work in progress.

So I think everybody agrees, the public health system in particular, is going to have to address much more assiduously in the years ahead.

NANCY DICKEY: But again, to take a more positive perspective, I said to somebody earlier, I'm a pessimist but I really don't want to be. There are pieces in, at least the House bill, that address building increased infrastructure for public health. There are specific sections that address the value by attaching payment for things like smoking cessation, things that have not been included in an awful lot of payment mechanisms.

So I think that perhaps if you add that to the concepts of patient-centered medical homes and accountable systems, we will have opportunities for a number of these communities to begin to grow up and then because we're very competitive, we may find that we can use those communities to encourage others that the cost of care goes down if you have the infrastructure of public health and then the primary care overlay and we'll begin to use those to put the next layer.

I don't think we're gong to get this all done in the first cut but we've proven, as you said, that if we take it a slice at a time, we don't make any progress at all.

ED HOWARD: I'd just make the observation that most frequently I've read criticism that these bills actually do too much or try to do too much rather than that they don't try to do enough. There are at least a substantial minority in Congress who would say maybe we are biting off more than we can chew. We have a whole raft of questions about, why am I blanking on the non-sexist word for manpower issues.

NANCY DICKEY: Workforce.

ED HOWARD: Thank you very much, workforce issues, and let me just attack a few of them because they are related. One of them has a pretty simple solution for the shortage. Why not make Medicare and Medicaid acceptance required of all providers

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in order to close the access gap? Sounds like a reasonable idea, doesn't it?

NANCY DICKEY: Didn't Massachusetts try that?

ED HOWARD: Would our Massachusetts people like to address that?

SHARON LONG: No [laughter]. I'm not sure I know.

ED HOWARD: Susan?

SUSAN DENTZER: Well I'm not sure exactly where the question's coming from. Physicians are required, yes?

ED HOWARD: Let me just sharpen it a little bit. One of the ideas floating around as these bills started to get marked up was the idea of linking participation in Medicare, participation in a public option, a public plan as a way of making sure that access for that group of people, presumably more the subsidized folks, would be relative guaranteed since docs and hospitals couldn't afford to write off Medicare. As I recall, it was not met with a unanimous approval.

NANCY DICKEY: I'd say that's the understatement of the day. That's perhaps the answer to his question.

SUSAN DENTZER: Well and a fundamental issue here is are you going to require providers to do certain things number one but also what are you going to pay them? Now in Medicare, obviously the federal government has levers to control what physicians are going to be paid and that's what we've been

talking about, some of the payment reforms that would basically make it more attractive for primary care physicians in particular to see Medicare patients.

On the Medicaid side, it's a little bit more complicated because Medicaid is jointly run between the states and the federal government and jointly paid for between the states and the federal government and localities. So to raise payment rates in Medicaid means that the states have to go along with that as well and the stats, as you all know, are in a pretty injured position at the moment with respect to their economic considerations and their fiscal considerations.

So how we address that, over time, will be an issue. In the House bill, the Medicaid expansion that would take place would be entirely paid for by the federal government. So that's an attempt to address this notion but it's not utterly obvious that that is going to mean the payment rates get bumped up in Medicaid. Nancy can say more probably from direct experience about how low Medicaid rates really are but they are a serious barrier and until they're addressed, I think access for Medicaid patients probably is going to be an issue.

NANCY DICKEY: They vary state by state but they oftentimes are as much as 30-percent of what Medicare pays, which is perceived, in most places, to be probably 80-percent

of what private insurance pays. So now you're getting down to a fraction of the cost it takes to drive the process.

I would probably say the best reason though, Ed implied, is that while physicians and other health care providers are not a big enough group to kill health reform on their own, if they are incensed enough to try to get all of their patients opposed to a bill, they can at least seriously disrupt the likelihood of passage. Mandatory participation would probably be adequate to get that kind of activity going.

ED HOWARD: And this one actually addresses the same question at a state level and initially it's directed to you Sharon. How have state government payments changed since 2006 to docs and hospitals and how has it affected or how will it affect access in your opinion?

SHARON LONG: Well one of the things that Massachusetts did in its health reform law was to raise Medicaid payment rates for physicians and hospitals. So they did address that. They're not as high as, I'm sure, the doctors and hospitals would like to see them but they were moving those up to address the capacity issue.

I think one state that's done this kind of along the lines of the earlier questions is Minnesota, which has made a requirement that if you want to participate in Medicaid, you have to participate in the state government health insurance

program, so ways to tie other programs together to increase the incentive to come into Medicaid.

ED HOWARD: And this one's addressed to both of you who are familiar with the Massachusetts situation. Were co-payments or are co-payments and deductibles still included in these insurance programs and have they been altered?

DEBORAH DEVAUX: They are still included.

ED HOWARD: And that is not affected by the changes in your payment experiment then?

DEBORAH DEVAUX: In the Blue Cross/Blue Shield contract, we are applying that contract to our HMO right now. Employers and members can purchase different types of benefit packages but all of them include some level of co-payment or deductible in the product.

What we want to do, as an earlier question addressed, is to start to introduce some alignment between the members and the physicians so that lifestyle issues, members who are focused on maintaining their health either through smoking cessation, weight loss programs, etc. on the other side do get rewarded for that in addition to having co-payments and deductibles for medical services.

SHARON LONG: And one thing that the state did with the minimum credible coverage, which is setting the floor on what counts as insurance in the state was to place restrictions on

what out-of-pocket costs could be for the year at maximum expenditures.

So there are some kind of push backs on out-of-pocket costs and for people who are eligible for public programs under 150-percent of poverty, there aren't co-pays. So there are some limits on who's subject to co-pays but there are also some caps on how high they can be.

I should also say preventive care is now for everybody in the state, for insurance to qualify; it has to be outside of the deductible. And so, you've seen an increase in preventive care in the state.

ED HOWARD: And continuing on this same theme, this is a question addressed to Dr. Dickey. MedPAC has proposed, that'd be the Medicare Payment Advisory Commission, has proposed increasing primary care reimbursements and decreasing specialist reimbursements in Medicare. Many private primary care physicians have actively objected to decreasing specialty reimbursements. What would your advice be to policy makers on this issue?

NANCY DICKEY: Well I think that to the degree that there's a single bucket of Medicare dollars that are going to be used to reimburse providers, physicians, and advanced practice nurses, and others, the reality probably is that some of the adjustments, if we want to attract more primary care,

will have to come by adjusting it out of subspecialty payments. Now that may not be payment per service.

It could be that you reduce the numbers of specialty services, which is part of that bending the cost curve many of us think will occur. So I'll get paid just as much for every coronary artery bypass I do. Maybe I just don't need to do as many of them if I follow evidence-based information.

Obviously, I would assume that those primary care physicians who don't want to take a pay increase off the backs of their colleagues assume that somebody will put additional dollars into the bucket and therefore, specialists continue to get paid at the rates they are and will simply raise the tide and if that's an option, we'll all go for that. None of us want to be divisive within our peer groups.

I don't think that's an option. I think when you talk about the fact that the money that's in the system needs to actually either go to providing more care or somehow bend it so there's even less money in the system suggests that we're going to have to take the dollars that are there and we're going to have to spread them around differently than we have. So it's nice that you want to take care of your colleagues but I think the data says we need more primary care.

ED HOWARD: Okay. Here's one that goes back to something that several of you have referenced and that is the

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importance of preventive care. The questioner states 37 states currently require insurers to provide prostate cancer screening as a benefit but then will lose that benefit in currently debated health bills because they are not recommended by the U.S. Preventive Services Taskforce. How can we ensure access to these important measures?

If I can add a second half of that question, how do you judge what's an important measure if you don't take the word of the preventive services taskforce? Is there some higher authority?

NANCY DICKEY: Well let me reference the comparative effectiveness research that is addressed in the bills and has had a fair amount of conversation. About half of what we do in medicine today has pretty good research that says this makes a difference or it doesn't make a difference. What the bills have attempted to do is say for that 50-percent that we have pretty good data, we ought to practice based on what the data tells us is good practice.

For that 50-percent for which we do not have good data then we ought to be spending some of our research dollars to collect the data. One way to do that, by the way, would be to say for that 50-percent of care for which we don't have data, if Blue Cross is going to pay for it for you, you should be enrolled in a study so that three years or five years or seven

years from now, we would be able to give you data that says it either helps to get this care or it doesn't help.

So we could then begin to say, at least for insurance purposes, for which a third party is going to pay for your care, we will pay for those things that appear to make a difference in your longevity, in your quality of life, in the timeliness of your recuperation and then if you want to buy those things out of pocket for which there isn't good evidence but which either your physician or someone has convinced you, you probably want to have it anyway, that's fine. You can always write a check for that.

You just can't ask your insurance company to pay for that but if we don't have the data as we don't for about half or a little more than half of what we already do then we've got to find some way to collect the data so we'll know where to put those things on the list or off the list. Is that a fair description of prepared effectiveness?

SUSAN DENTZER: And just to say a word more about the specific case of prostate cancer, it sounds like it should be a slam dunk. If you have prostate cancer, you want a test that tells you, you have it. You want to know sooner rather than later.

Well, it's not that simple. Prostate cancer grows very, very, very slowly. The odds are in many individuals, they will

die of something else not the prostate cancer that they have. We only now are beginning to be able to discern which prostate cancers will grow fast and which will grow slowly.

Several years ago, a study was done of people who died, young men who died in Vietnam and a lot of them had the early stages of prostate cancer. Now they weren't dead and they weren't going to die of prostate cancer. They were going to probably to die of something.

So when you look at things like screening tests, you have to not just say does the screening test show what I think it shows. Does it show that I have prostate cancer or not, or not me obviously but a man. Then what is the intervention that that individual has? Does the intervention kill the person? Do I get excess surgery? Does the intervention make me impotent when I didn't have to be made impotent because I could have gone to a different surgeon or I could have undergone watchful waiting?

You have to take in account this whole array of things that get done to people and then you have to say once all those things get done to people or not get done to people, what do they die of? So you have to follow them for a really long time and find out whether they died of prostate cancer or something else.

When all of this has been looked at by the U.S. Preventive Services Taskforce, the answers are not clear that prostate cancer screening is always a slam dunk. It is clear that some people get treatment that they don't need and die of treatment that they didn't need for a disease that wasn't going to kill them.

So as Nancy says, until we understand all of this, it really comes down to are you going to recommend that we take our precious health care resources and spend money on them or are we going to spend money on things that we have some evidence on while we gather the evidence to figure out whether we really should be doing these other things or not.

NANCY DICKEY: There was an article in the, I'm sorry I don't even remember the source, it was an article about some British health care coverage and my legal counsel for my academic health center came in and thought he was going to start a fight I think because he said the Brits have put a dollar figure on it.

They've decided that if a cancer treatment costs more than, and I'll get the numbers wrong, I apologize but more than $20,000 and doesn't extend your life by at least 90 days, they're not going to pay for the care.

So they began to say we'll spend this much money for this much longevity. I said I'm not sure that's all bad. We

have treatment interventions that cost tens of thousands of dollars that we can't demonstrate, extend your life at all and being a cancer survivor, I could tell you some of those treatments might make whatever extension of life you get almost not worth it. Fortunately for me, I'm hopefully cured.

So we are going to have to start asking difficult questions about which interventions we do, whether we do interventions for some groups and not for others because different groups of people respond differently but we should do it based on science, on having collected information from an adequate supply of people that we can then sit down with patients one on one and give them some information in which to make intelligent choices.

To do that, we'll probably move a lot of things that we think of as routine care today into experimental models where we begin to collect this information. There will be those who immediately scream you're rationing care but the reality is that if we're giving you care that costs you or, more likely, someone else money and doesn't improve your life then we probably ought to save those dollars for something that could make a difference in your life or somebody else's.

So it's going to be a tough time, I think, as we begin to explain to people that this thing we think of as great science often doesn't have much science at all behind it.

ED HOWARD: Well that is a more profound thought than usually passes the lips of our panelists [laughter]. It demonstrates, to me, the high quality of the conversation that we have been having on this bundle of issues. Let me just ask you to fill out those blue evaluation forms I see some of you writing on now as we finish up here.

Our thanks also to the Robert Wood Johnson Foundation for their participation in and support of this briefing. Thank you for staying with this not uncontroversial bundle of issues that bubble up in a whole range of places in this debate and ask you to join me in thanking our panel for a very thoughtful and useful discussion [applause]. Thanks very much [applause].

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