Scoring Savings: How Can Quality Improvement Reduce Health Care Costs?
The Alliance for Health Reform and the United Health Foundation
July 13, 2009

[START RECORDING]

ED HOWARD: Let's try to get started if we can. Wow, you people are really responsive today. I'm usually able to say that there's some seats up front. There are no seats up front and we ask you to bear with us, use the minimum space you can possibly get by with so that we can accommodate as many people as we possibly can. This has proven to be, not amazingly enough, a very popular topic and we thank you for coming.

I want to welcome you on behalf of Senator Rockefeller, Senator Collins, our board of directors, to this briefing on how you can bring greater value out of the $2 trillion plus that we spend on health care every year and how we can bend the cost curve, as the cliché goes, at the same time.

Our partner in today's program is the United Health Foundation, which for the last 10 years or so, has been the charitable arm of the United Health Group. I want to thank Dan Johnson who's the Foundation's Executive Director and Reed Tuckson, the Executive Vice President and Chief of Medical Affairs at United who also happens to be a board member of the Alliance and I'm pleased to say a founding board member of the Alliance in other incarnations before United was smart enough to hire him a few years ago.

Now as the reform debate heats up, analysts and advocates are all looking for ways to make the health care system work more efficiently and as big an accomplishment as it would be to pass a deficit neutral bill that expanded coverage to the tens of millions of uninsured in this country, it would not be enough. In fact, as *The Washington Post* pointed out in an editorial today, we'd still be faced with the upward trajectory of costs that threatens to crowd out other spending, public and private.

Now today, we're going to look at some of the proposals for bending that cost curve and enhancing the value we get from those trillions in spending. We have some real life experience to look at, some thoughtful macroeconomic commentary on how those steps fit in to a national reform plan and we have a positively outstanding panel to examine these questions.

A couple of quick logistical notes, by tomorrow, you'll be able to view a webcast of this session on kff.org, that's a service that Kaiser Family Foundation, it's a little more difficult than it was with kaisernetwork.org. You have to enter Alliance for Health Reform in the search box and then look for the webcast entry. You'll also, in a few days, be able to view a transcript of the briefing along with all of the materials that you have in your kits.

Let me remind you that there is an evaluation form in those kits that we'd ask you to fill out at the appropriate time and a green question card when we get to that part of the program that you can fill out and we'll try to get your question asked of our panel. So if you would take this opportunity to turn your pagers and cell phones off or vibrate or whatever it is you have to do, let's try to get started.

As I said, we have a truly outstanding group of folks with us today and we're going to start with Len Nichols. Len is the Director of the Health Policy Program at New America Foundation and that rarest of breeds, an economist who speaks English [laughter].

Len's held senior positions at The Urban Institute, at the Center for Studying Health System Change and at OMB during the Clinton Health Reform Debate and today; he's going to help frame our discussion about bringing better efficiency to the health care system while expanding coverage. Len, thanks for being with us.

LEN NICHOLS: Well thank you Ed for having me and thank you all for coming. I hope you all remember the Robert Frost poem about two roads diverge into yellow wood because what financing is really about is making choices. At the end of the day, that's what politics is really about and at the

end of the day, there's going to be a series of votes and the thing about votes is it's either aye or nay.

So it really does force pretty hard choices and what we're going to do today is try to talk to you about what is, in some ways, the hardest set of choices and that is how are we going to pay for this. To put it in perspective, I think it's useful to remember, everybody take a deep breath, every year we actually spend two-and-a-half trillion dollars on health care in this country and a little over $850 billion of that is federal government.

So when you get down to it, we're already spending a lot but I think it's fair to say that it's going to cost a lot more if what we really want to do is cover all Americans and I think it's reasonably fair to say most of us do. Certainly most of us in this room and most of the people in Congress do. So for what it's worth, my ballpark estimates of what it would take to cover everyone for a given year, roughly in 2010, ranges between $125 and $175 billion depending upon how generous the benefit package, how generous the subsidies and so forth.

You learn, I'm sure you all know in all these financing discussions, almost everything can be dialed up or down. What CBO's about is teaching you kind of how to turn the dials.

So we spend a lot. We're going to spend a lot more.

Let me just put this amount in context though because I think it's fair to say part of the sticker shock over the 10-year price tag and you've heard everything from one trillion to $1.6 trillion, etc., part of that is clearly coming on the heels of the stimulus spending of $800 billion or so and the TARP at $400 billion or so and I don't know, autos, I can't remember how much of that.

It's all big monopoly money right, but it's important to remember that $1.6 trillion over 10 years is 0.8-percent of GDP, which is not that big a deal as share of GDP in a normal time. We don't live in normal times. Clearly I think it's fair to say we do have pretty strong agreement, we've got to pay for this. We can't write a blank check. This has to be pay-go. So that's what all the stern and drain is about.

So what I want to do very briefly is give you big picture financing sources, which again, are really financing choices and lay out some of the arguments, pro and con, but I want to spend just a minute before I get too deep in any serious substance and talk about why financing choices and the successive reform are actually inexorably linked.

You might have heard this rumor. We are on a trajectory that we cannot afford. If we don't figure out how to make somehow health care costs per capita grow slower over time, we're on a trajectory where an increasing fraction of

our workforce cannot afford health insurance and health care as we know it. So we don't really have a choice. What I sometimes say is all these hard choices boil down to the fact we don't really have a choice. We have to figure out something to make health care more affordable.

That means that even though it might be tempting, I don't think anyone is going to propose paying for this just by writing a check, that is paying for this just by taxing ourselves now. Because if that's what you did, then you wouldn't be doing anything about making the system more efficient over time and enabling us to sustain what we have now much less what we hope to and should add and that is access for, I would guess today, probably 52 or 53 uninsured million Americans because every person that loses his job, two people lose private insurance. That's a heck of a lot more uninsured out there than there were in March of '08.

So the point is it matters how you finance this stuff and it's pretty smart to include within your financing package some things that are going to try to enable your system to become more efficient and hopefully, in some ways, I'll be blunt about it, force it.

What are the big picture? We could just raise taxes of course and there's a lot of discussion about that and there's lots of ways you can tax, lots of things you can tax like high fructose corn syrups, my new favorite, since I grew

up drinking Coca-Cola my whole life, I didn't know, Gail didn't tell me that it was bad for me.

So when I finally figured it out and I switched to Coke Zero or this stuff, which is worst than Coke Zero but it's good enough [laughter], I'm now in favor of taxing high fructose corn syrup. It's perfectly timed although I understand in Iowa that's not too popular.

We could also of course, euphemistically reduce taxes that insure, i.e. tax health benefits and, as an economist, I would say this is a good idea. As a person who lived in Washington for a long time, I will tell you it's painful and it's impossible to do it in such a way that it'll satisfy everybody.

So is everything else but it is a good idea because it probably could both make our system of financing more fair and help us impose a little discipline about health care cost growth over time and trust me sports fans, we need all the discipline we can muster. So I still am for this even though some people are not.

Then third and this is really what we're going to focus on today because I think it's both the most controversial and the most important part of the financing package and that is essentially what can we say out of our current spending that we can capture, I put capture in quotes because what that means is how much can the federal

government bring back from what we're spending as opposed to what we might be able to say about individuals because nice though that is and surely that'll be helpful on election day to spend it on coverage, you've got to get the money back and therefore, how much can the feds get back. I think that's really what the discussion is all about.

Now we're going to hear a lot from people from United and IBM about how they have some very creative ideas about how to do this and I highly applaud all those efforts and I think that's a great way to think about the problem but I also want to give you the big picture since that was my suggestion from Ed.

So I want to lay out in my view, why we have a chance to pull this off and then talk a little bit about what I think we'll do. I think it's fair to say and I hope you can see this, the consensus inside the Belt Way, both parties, is that what we really have to do is achieve economic and fiscal sustainability.

And of course that really means you're going to have to reduce cost growth, especially the Medicare program, but it turns out of course the Medicare program is the system. So it's surely about both but you've got to reduce cost growth in the Medicare program. To do that, you're going to have to realign incentives.

No one thinks just whacking prices or just stopping

paying for this is going to do anything. You've got to really change incentives and Gail and I can wax poetic about how bad the incentives are. We will be poetic later if you'd like but trust me, incentives are bad. We can fix a lot of them and we can't achieve cost growth reduction that's sustainable unless we do fix incentives.

Some people say let's just do that and that of course, is all about payment reform. A lot of people say let's just do this first and then after we get wonderful savings then we can do reform later. Here's the problem, big problem. Two-thirds of hospitals, right now, lose money on Medicare and that is not, although some will quibble with this, that is not because Medicare underpays them. That is because they are inefficient.

So if you were to go to those same hospitals and say we decided to do payment reform first without covering the uninsured that they, by the way, have to take care of every single day, every single hour, I just think it's a complete nonstarter.

So while coverage is a moral question and everybody up here knows, some of you know, I can quote Leviticus, Matthew, the Koran, the Book of Mormon, whatever you want about why we ought to do this but I will tell you it is also a technical bribe in the sense of the 14th century potentates saying, look, what we want to do is cover people so that we

can buy time for our system to become as efficient as we need it to be. I submit to you that's why it's linked. That's why you can't do one without the other and therefore, they are in exorably intertwined.

Now I think sequencing makes a lot of sense. I think there's lots of ways you can build this and you can do it all in one day but I do think you can't realistically claim you can do cost containment without coverage expansion nor would you hope to get a bill passed that just did coverage expansion without doing cost containment.

However, you now have figured out for this to work, it's going to take major league leadership. Well my favorite quote from John Adams' book, David McCullough wrote where John is sitting there writing Abigail, where we learn everything we need to know because the way he wrote to Abigail is everything you need to know and what he's writing, he's in Philadelphia.

He's watching Madison give a speech. He's looking at Jefferson, Franklin, and Monroe, and Washington, and he's writing Abigail and he says I just don't think we can pull this off. We don't have enough talent in the room [laughter] and then I think about today.

So what I had to say is you know what? He didn't think they had the talent in the room because the talent doesn't reveal itself until a country tried to form or form

itself, is really tested. We are now tested and leadership will either rise up or it won't. So part of what I do in my spare time is try to create inspiration.

So I made a group called Health CEOs for Health Reform. The title's self-explanatory. I highly recommend you check these people out. You have a little two-pager. It's front and back, a one-pager in your handout, which talks about the white paper they released, which looks like this.

Here's the deal. These people run real systems. I'm just a simple old country health economist [laughter] but they run real systems and here's what they concluded. Fee-for-service is unsustainable. There is no reason we can't hold providers accountable for quality and efficiency targets and that we should start this afternoon because it's going to take a decade.

We've got to get providers some tools including malpractice reform; they wouldn't let me make a new agency but a new office of coordination. They call it the Science of Health Care Delivery where you teach a lot of what Simon knows, where you teach how to do things right. Make it clear to providers fee-for-service is not going to be as profitable going down the road as moving into more bundling payment alternatives.

What these CEOs believe and you could look, they range all kinds of, they're across the spectrum in terms of

the sectors, it's not just integrated systems although they're part of it, these folks believe if you tell American CEOs where you're headed and you're clear about your objectives and you're clear about what you're going to incentivize them to do, they can friggin' do it in a reasonable amount of time but you've got to be clear. Your job is to get your bosses to be clear. I will stop now and let the panel continue,

ED HOWARD: Great. Thank you very much Len. Next, we're going to hear from Simon Stevens. He's the Executive Vice President of the UnitedHealth Group, head of its Center for Health Reform as well as its global health division.

He was a Health Policy Director for British Prime Minister Tony Blair and those of you who know that we have a working arrangement with the Commonwealth Fund might want to note that he's a former Harkness Fellow, which is a project of the Commonwealth Fund.

He's here to share with us, as Len intimated, some of United's experience in engineering better efficiency and higher quality in its programs and trying to figure out what that would mean for the broader health care system and we're very pleased to have you with us Simon.

SIMON STEVENS: Thank you very much Ed. As we get going, there'll be certain telltale signs in my accent as to the truth of my background as Ed just described - an accent

from the very north of Minnesota [laughter] where United Health Group is headquartered.

So I just want to start by strongly agreeing with Len, as I often do when I find myself following him, we clearly need universal coverage and what's more, we know for that to be sustainable, you've got to match that with tackling the affordability of health care. The two go hand-in-hand. They are two sides of the same coin.

So what I've been asked to do is to get very specific and practical about some of the ways in which it might be possible to both raise quality and also take costs out of the system. So let's just start with the Willie Sutton test. Where's the money and what's the opportunity?

As Len said, the country is going to be spending about $2.6 trillion on health care this year. Of that, seven-percent is going to be spent on the financing, the cost of financing the system and 93-percent on the delivery system on the actual provision of care. If you look down the right hand side there, you see the big building blocks of cost as you'd expect. It's about $800 billion a year on hospitals, over $500 billion on physicians, and then about a quarter of trillion on drugs, slightly less on home health nursing, home services, and so on. So that's kind of what the cost map looks like.

What I’m going to do is share with you the results of two recent research reports that our Center for Health Reform has published. You’ve got them in your pack. I’m going to start with the blue column in the center - the administrative cost opportunity - and then talk a bit about medical savings opportunity, the right hand column.

So let’s start with the smaller of the two columns then, the administrative cost piece and what we can do about it. The fact is that all too often, I think your experience, my experience, as patients in the health care system trying to interact with it is, it is confusing, it’s hard to navigate. We know the doctors, hospitals, health plans, also find it a very frustrating waste of time and money with the amount of administrative processes that are very paper based or duplicative or redundant.

So fixing these processes is the unsexy part of health reform - but it must be done. The study that you’ve got in your pack called “How Technology can Cut Red Tape,” shows three broad approaches for doing this, that I’ll just briefly summarize for you now.

The first entails much stronger standards set right across the health care system for the way in which information flows around the system. The second requires stronger system wide payment accuracy approaches and the third, taking out some of the duplication that doctors and

hospitals experience when they have to be credentialed by all the different payers in the system. Doing those three things - and I'll give you a couple of examples as to what they will actually mean in a moment - doing those three things, we estimate would save around $330 billion in national health expenditure over the course of the next decade.

In order to get that, we think that there needs to be shared action right across all the payers - governmental as well as private - hospitals and doctors, with a set of milestones set in law that would apply to everybody. Let me just give you, as I say, a couple of, three practical examples of what I'm talking about. You'll see that, in some ways, this is very prosaic but it also implies significant savings opportunities.

Len, I think was quoting Leviticus, Matthew, and the Koran; I'm going to instead just confine myself to the science fiction writer, William Gibson [laughter], not necessarily the same sort of religious category as the three that Len talked about but I think he got this particular point right. He said "The future is already here - it's just unevenly distributed".

I think if you look not just about what I'm about to talk about in terms of this admin stuff but more generally around how to reform the health care system, how to modernize delivery, that holds true. There are parts of the country,

there are systems, there are processes, there are specialties where the good stuff that ought to be happening across the country as a whole is already happening and the question is: how do we generalize and how do we scale it? So three simple examples of what this admin simplification stuff might mean.

The first is that most of you with health insurance presumably have a card that looks something like that. Every time you go and see your doctor or hospital, you have to present your card and in many cases, certainly the one that I have here, there's a magnetic stripe on the back. However, what you then observe is the person at the doctor's office taking it to a photocopier and photocopying it rather than doing any swiping. Sixty-percent of the time, that person will then have to get on the phone and call some call center somewhere to ask about somebody's eligibility. So the bit on the back is not being used and the print on the front is.

That is just a very simple example. If we got proper connectivity, all the doctors' offices, all the hospitals, a similar set of standards right across the system, we would be able to take out $18 billion in national health expenditure over the next decade.

The second example up there are these monthly health statements. I don't know about you but my wife who, we had a second child last July 4th, and the number of bits of paper that came as a result of that, many of them called

Explanation of Benefits and then very confusingly marked "This is not a bill". Well what is it then? Because it's not terribly explanatory, and I'm not clear what the benefit of getting it is. But apart from that, I suppose we should be grateful that there is, of course, a very easy opportunity to replace this stuff with a monthly online health statement. This is already happening to some extent but in a number of states, state law requires that those unhelpful bits of paper are dispatched to each of us every time we interact with the health care system. Getting rid of them: $14 billion in admin savings over the course of the next decade.

Then last but not least, electronic payments. We know that about 20-percent of doctors' offices at the moment are submitting all their claims electronically, i.e., 80-percent aren't, and only three-percent are getting all their payments electronically. Now the opportunity cost there is something over $100 billion a year, very straightforward. The technology already exists. It can be done securely. We've just got to mandate this via the date right across the health care system.

So just to give you a flavor of the kinds of ways and the kinds of opportunities that are sitting there.

Of these $330 billion savings, we think that about half would go to doctors and hospitals. About a fifth would go direct to the government in its capacity as a payer in

Medicare and Medicaid, about 30-percent to health plans, but there are various ways the government could get its hands on more of that if it so choose. So that's the transaction and administrative part of the system.

Let me now just go on to the much bigger opportunity, which is obviously around managing health care and medical costs themselves and the basis for what I'm about to show you are our experiences as a largeish payer serving about 70 million people each year both in the employer space but also as individuals, Medicare, Medicaid, buying about $115 billion in health care each year.

I think what I'm going to say here is, I think going to tie up with some of the points that Janet's going to make hopefully very closely, because what we have found is that you have got to, first of all, get very practical about making transparent the performance differences that exist across health care. All the academics, all the researchers will tell you that they are there. The question is: can you explicitly identify them? We've done that, identifying around 100,000 physicians who are - against the evidence-based guidelines set by their specialty societies themselves - delivering higher quality care and at up to 20-percent lower cost.

You've then got to share that information with the consumers. You've got to incentivize the choices that

consumers make and you've got to change the payment models for the physicians and for the hospitals. This is not just theory. This is practice. We're already doing this now in cardiology, in oncology, primary care, I can discuss in more detail what that looks like. We're doing that for new payment models with diabetes as well.

Now, this is all very well you may say. This is happening inside parts of the commercial market space. What about Medicare? This is probably the most famous chart in health policy showing, as you know, the arbitrary variations that exist in Medicare spending right across the country, underpinned and driven in part by the fee-for-service misaligned incentives that Len was talking about.

For example, Pima County, Arizona, seniors are going to cost about $8,000 a year. Miami Dade about $14,700 this year. That is not a variation explained by differences in health need or by differences in the appropriate provision of care. So the real question is: what are we going to do about it? Because unless we do something about it, we know that the Medicare Hospital Trust Fund will be insolvent in just eight years' time.

Therefore, the second paper that you've got in your pack is an attempt on our part to look at 15 very practical programs that have been shown to work either inside parts of Medicare or inside other parts of the health care system and

to answer the question: what could those savings be - savings that would accrue to the federal government, and be financially scorable if they could be applied more systematically.

We have found that there are a variety of routes to getting perhaps $540 billion in savings through these. Very simply, give you three quick examples:

Nursing homes. The number of seniors admitted from nursing homes to hospital with chronic disease who could be supported with intensive nursing and other medical support in the nursing homes is substantial. We run a program called Evercare that has been demonstrated in well controlled studies to reduce those unnecessary hospital admissions by over 50-percent. Applied more generally across the system: $166 billion in savings.

Readmissions. We know that one in five seniors is readmitted to hospital within 30 days. Through better discharge planning and home-based support, that number could be at least a quarter lower.

So my point simply is that this is not speculative. This is the art of the possible. A lot of the things that are being talked about as the theory of health reform already are in practice somewhere in some program in some part of the country.

So we’re being too pessimistic, I think, if we just

gave up on attempting to identify savings from within health care itself and instead decided that we have to revert simply to revenue sources outside of health care in order to do the necessary coverage expansions, which I think we all support.

Thank you very much.

ED HOWARD: Great. That's great. Thank you very much Simon. We're going to shift the order a little bit from what's listed on your agenda and go next to Janet Marchibroda, who's the Chief Health Care Officer for IBM.

Janet, I'm pleased to say, has graced other Alliance programs in her previous role as the founding CEO of E-Health Initiative and the Executive Director of Connecting for Health, this project that the Markle Foundation, with some help from the Robert Wood Johnson Foundation, put together and I think, thanks to Janet, you'll notice that Simon talked about connectivity and interoperability and Janet actually explained to me what those meant and at the moment, I understood it.

So I'm grateful for that and it's also worth noting that IBM has a rich array of activity in the area that we're discussing and Janet's going to share some of those stories with us today. Janet, thank you very much for being part of the panel in your new job.

JANET MARCHIBRODA: Thank you Ed. It's a great pleasure to be with you today. As we explore ways in which we

might reduce health care costs in this country, I thought what I would do in my new role is spend just a couple of minutes talking about what IBM has done with its own employee population.

We actually cover health care for about 450,000 people in this country in 2008, which represents a combination of employees, about 118,000 of them, 93,000 retirees, and 235,000 dependents. We spend, well at least in 2008, we spent $1.3 billion in health care. IBM supports health care reform because it is both a competitive necessity for our nation’s economy and also because it’s good business for us.

We believe that broad systemic reform is necessary to fix our health care system and that a successful agenda will build a patient-centered accountable and competitive health care market that delivers effective outcomes and improved costs.

So earlier, what I’m going to share with you is a little bit of our story about where our health care costs were and how we were able to bring them down considerably over the last couple of years, few years. Earlier this decade, we were experiencing, IBM, with its health care costs, was experiencing double digit increases in health care costs in the U.S.

So our trend rates, if you looked at between 2000 and

2002, they ranged from 9.3-percent to 13.3-percent and our average trend during that time period from 2000 to 2003 was about 8.5-percent a year.

In that time, when you looked at what we were doing at the time, the strategy we were using to contract with our vendors was really not optimized for quality, service, efficiency, or price. We had a benefit strategy that we contracted, offered a lot of choice. We actually had about 210 health plan choices for our employees.

Population, if you'll remember at the time, population health status and prevention, clinical care needs for chronic diseases, and coordination of care were really absent in the market place and accountability and transparency were nonexistent for consumers in their decision making processes.

So what we did is we employed something that we call Healthy People for High Performance program and it really has the components that are laid out here on the slide, value, in terms of quality and cost, meaningful choices, sustainable cost structures, prevention and primary care, and I know there's a lot of discussion about that today, smart decisions, and of course, privacy and health IT and we got a boost here with some of the significant investments made by the American Recovery and Reinvestment Act passed in February of this year.

We invest in health care to realize the productivity and innovation of people. Our people are our greatest asset and to recognize the importance of health care partnerships and accountability.

So let’s talk a little bit about some of the key components of our strategy and how we were able to realize some significant savings. The first is around employee-centered investment. What we did is let eligible full-time employees have access to at least one no contribution medical and dental option.

We also included per person pricing for dependents. So based on the number of people, we continued, we were able to continue to preserve access and choice and then we added some cash back for those who opted for no coverage.

In terms of incentives for healthy choices, we did, through our Healthy Living Rebate program, put a lot of money back into incentives for employees to make healthy choices, healthy behavioral choices. For example, they received $300 in rebates if they participated in physical activities or nutrition programs or executed on a preventive care plan.

We also put in place a children’s health program particularly addressing issues around obesity. From 2004 to 2008, we actually paid out $133 million for this Healthy Living Rebate program.

Three, we focused, of course, on prevention and value

and medical care. We have a heavy focus in this area. We actually provided free coverage or free deductible coverage for preventive care for IBM employees. We eliminated the deductibles related to routine care, primary care, and we provided some aggressive support for those with chronic disease.

Then finally, thinking about some of the electronic tools, we also provided personal health records and online tools to help individuals navigate their own care, learned about better behaviors to support some of those, and actually 64,000 of our employees completed an online health risk assessment in 2008.

In terms of health care reform, many of you have seen, and we've been a long supporter, an early pioneering supporter of primary care and the patient-centered medical home, recognizing that coordinating care across all of those who work with the patient around the care system was really important to improve quality and reduce costs.

We've done some other things, joined a business coalition to support the uninsured and also have supported heavily the use of information technology to drive improvements not only in the administrative inefficiencies that we've had in our health care system that Simon talked about but also to enhance clinical decision support at the point of care and to support value-driven health care from a

population health perspective.

So what I've done in these next two slides in the interest of time, I've taken these strategies and given you a picture, and these are in your handouts, of the different things that we did beginning in 2004. So we started in '04 with an employee-centric subsidy allocation.

We improved some of our purchasing strategy, put in place some personal management tools for our employees in '05 and then we moved to offering 100-percent coverage for prevention with no co-pay in 2006 along with removing deductibles for primary care and offering some rebates as well.

Our next slide and you can see the trend numbers with each year. Then in '07, we both stirred much more support for care coordination, behavioral health advocacy program, really focusing on primary care and coordinated care in '07 followed by our Child Health Rebate program, nutrition guidance in '08 and now in '09, continued focus on primary care, the medical home pilots that we're involved in as well as driving use of generics during that time period.

So in summary, let's look at the numbers. Today our employee population is healthier and our costs are much lower. For both cost and trend, IBM is routinely at or below market. Our employee costs remain lower than benchmarks.

In '08, our costs were $8,585 per capita while the

market place benchmark was a little more, $8,895. Between ‘04 and ‘07, our internal health assessments showed dramatic declines in employee health risks. Our participation in our wellness programs rose sharply and we reduced, our employee population reduced risky behaviors such as smoking while increasing healthy behaviors such as exercise and healthy nutrition.

If you go to the next slide, you’ll see this is an interesting one here on the left and it’s not in your packet. If you take the average health care trend, it went from 8.5-percent during the period 2000 to 2003 to an average of 4.2-percent from 2004 to 2009, which is a 53-percent decrease. So we think that some of these strategies can be employed to reduce the federal health care cost spend as well.

Some other numbers here, as I close, 80,000 of our IBM’rs are physically active, a combination of education and rebate program that we offer and our generic drug utilization is increased to 96-percent without reducing medication options. As a result as a company, with our spend, we saved more than $1 billion in the last six years, $550 million from plan design savings and $350 million from aggressive purchasing.

Then finally, in closing, one of the areas that I don’t have on this slide where I think and I was pleased to read it, Simon in your report as well, is this focus on fraud

and abuse. We think that there's some additional savings that could emerge from that and we've estimated them maybe around $67 billion over five years. I think those are conservative estimates and more, twice that, more than twice that over a 10-year period.

ED HOWARD: Great. All right. Thanks very much Janet. Finally, we turn to Gail Wilensky who's a Senior Fellow at Project Hope, much to our benefit a frequent panelist at the Alliance presentations. Gail's a health economist. She speaks English too. She's the Former Chair of the Medicare Payment Advisory Commission and in recent years, she's become one of the top experts in military and veterans' health care.

She's currently President of the Defense Health Board and today, she's going to help us look at some potential concerns as we contemplate potential steps to enhance the efficiency and we're very pleased to have you with us Gail.

GAIL WILENSKY: Thank you Ed. I indicated I was going to be somewhat of a skeptic about the realistic ability to use very many of the scorable savings to expand coverage. There is an enormous amount of agreement among people in the health policy world about what it is we want in terms of health care reform. We want to get everyone covered or as close to having universal coverage as we possibly can.

The President has made clear that doing that without increasing the deficit is important. Many members of Congress

have also indicated that a real concern about the mounting deficit. This really does complicate our life. I think it is possible there might have been a little bit more flexibility in terms of time had we not had the TARP package, some of the auto bailouts and the stimulus package in the last 10 months passed but that really has complicated the willingness of the government to expand coverage to spend money basically on health care or any other major area without having some revenues.

There's no question that we need to moderate spending. I have become a true believer that we are cooked if we don't figure out how to slow down spending. It will make it very difficult for workers to get increased cash wages. It will be impossible for the federal budget to meet its various obligations and deal with entitlement spending.

You do not have to convince me that moderating spending is a very, very serious issue in health care for the federal and state governments. We have to improve quality. It's just ridiculous that we spend as much as we do and we have all of these indications of inappropriate clinical outcomes.

These objectives are highly agreed upon by people in right of center and left of center. There is some issue about whether or not you can do these in sequence or whether you're going to have to do them simultaneously and that's part of

what I really want to talk about this afternoon.

Numbers that Len cited are perfectly good numbers. We think that expanding coverage to almost everyone will cost one to one-and-a-half trillion dollars. So it depends exactly how generous the subsidies are and what the benefit package looks like as to whether you will have the lower end or on the higher end. There are some estimates. It could be as high as $2 trillion but I think generally speaking, most people are thinking it's not likely to be more than one-and-a-half or $1.6 trillion.

What I want to encourage people to think about is we can, there are reasons why this wouldn't be necessarily the best strategy. We can think about doing these sequentially very much in the way that the state of Massachusetts has done, which is by agreement across the state in terms executive and legislative branch to bring as many people as possible in. In their case, it's about 97-percent coverage. That's the easy part. It can happen very quickly.

They had two pots of money that the federal government doesn't have at its disposal, an uncompensated care pool of money that they could use and some waiver money that the feds allowed them to keep if they were to put it in the expansion of the uninsured but you could do it like that and then take on the much harder problem of trying to slow down spending, which is where they are now particularly

tricky in Massachusetts where one out of five jobs is related to the health care sector.

You can decide whether or not you want to increase revenue or reduce payments or you can try to use savings from reforming the delivery system to finance expansions. I want to be as clear as I know how. I am not, in any way, denigrating the critical importance of reforming the delivery system. If we don't do that, we have no hope of getting to a better place in the future with regard to sustainable spending and improved quality.

The question is, is it reasonable to assume we'll be able to get enough savings fast enough that CBO, who's an even bigger skeptic than Gail Wilensky, would be willing to score. I'm not sure how reasonable that answer is. I'm going to talk about it in a minute about what it would take in order to capture the savings to the federal government that would be necessary in order for this to go on.

There is widespread agreement about what we need to do in principle to reform the delivery system. We need to move away from this a la carte fee-for-service system for physicians, slightly better for hospitals and other providers in terms of how we reward institutions and clinicians. Those that provide good quality care and do it in an efficient way.

It would be good to develop accountable groups, the virtual reel, although I am somewhat troubled that I don't

hear much discussion about how it is we think we're going to get all those Medicare beneficiaries to want to sign up for the accountable groups.

God help the CMS administrator that tries to assign them arbitrarily or without their approval. I'm a little surprised that this is not receiving more attention but it's a promising idea in terms of how to try to change provider behavior. We need to continue the work we've been doing in terms of developing measures of quality outcomes and risk adjustment.

We need to understand that getting from where we are to where we need to be as a country, the scorable savings from the federal government is going to be tough not impossible just tough. We've got a lot to learn. I am all for having turbocharged pilots.

In the past, they have frequently not had the kind of outcomes we had hoped. We need to assume that's likely to happen again. We need to have legislative language that if they do work, they might go immediately into legislation because there's an unfortunate history that even when you have good pilots, they frequently don't make it to that next step, which is to actually get translated into legislation.

We just need to understand that while we have to start, don't want to say this, I can't say this too strongly that we have got to start moving in this direction. I am a

little concerned about whether or not it is going to provide a realistic way to finance very much of health care reform. If we say that we are going to rely on savings from reforming to the delivery system and I distinguish this from whacking at reimbursement to physicians, hospitals, nursing homes, home care, basically most of what was in the President's budget, we know how to do that.

We know the CBO will score that. It has precious little to do with reforming the delivery system. If we try to rely on savings that really are associated with reforming the delivery system, then we need to confront the fact that we will need to say what explicitly will we do if these savings don't materialize.

What kind of a fallback are we thinking about and most importantly to me, will the fallback that we think about be compatible with where we want the system to go in the future or will it just put downward pressure on prices and the traditional type of delivery for Medicare? How much of a time disconnect is okay?

Again I think we would have been more tolerant of some kind of a time disconnect if we hadn't seen quadrupling of the deficit in the course of the last year. For a lot of reasons, there's a lot of skittishness about seeing very much more increase in the deficit and if we go the other direction and say that it will be very painful to come up with known or

a certain revenue in order to expand coverage, how much and how fast will that be and will that be regarded as politically acceptable?

So, I am all for trying to start reforming the delivery system as fast and as furiously as we know how. God knows we can and better figure out how to deliver health care in a more efficient and affordable manner and do it with better clinical outcomes and better quality, but I'm a little uneasy about having very much of those savings be regarded on as financing the expansion.

I guess I've seen it happen too often when we have tried some of the pilots that on paper seemed perfectly reasonable, only to find for a variety of reasons that they didn't actually produce the kind of savings that we assumed.

So, I think the notion of thinking about financing the expansion and reforming the delivery system, slowing down spending, improving quality, can at least usefully be thought of as separate steps, although to the extent that you can sell to CBO some overlap, I would certainly be all for that. And to the extent that we can get more information from businesses, United Health Foundation or IBM or others about what they have found that works. These are areas to try in terms of our turbocharged pilots.

I am a little frustrated that so little pressure is being considered for the beneficiaries for the demand side in

terms of the public programs and I think it's going to be very difficult if we only try to put the squeeze on providers in terms of getting sustainable spending and improved quality. The political side of me understands real quickly why that's happening, but I don't know ultimately whether or not it will allow us to achieve the goal that we all want. Thank you.

ED HOWARD: That is terrific. Thank you, Gail. Let me remind you there are microphones both in the front and in the rear of the room that you can line up and ask your question verbally and you also have green question cards that you are able to fill out and hold up and someone will bring it forward to have the panelists take a crack at it.

Let me just try a couple of clarifying questions and I'll start with you, Gail. What are turbocharged pilots in the context that you are talking about?

GAIL WILENSKY: What it really is a shortening, what is traditionally the very long time span that is associated between the start of a concept of when it actually hits the ground, so to speak. Even to my astonishment, I have found even when the administrator, namely me, really embraced a pilot, it could take 16-18 months to get it through the process, through the contractual process and on the ground.

So to find a mechanism that would allow for a number of serious projects to start, and then it's really the follow

on statement is at least as important, which is to specify the outcomes that would be unsatisfactory and if they occur, the pilot stops, and if they don't, to have it be adopted into legislative language.

One of the problems that I have seen is that because typically the people who have been responsible politically for pushing the demo may not be along when the actual evaluation is done and we know what happened and so even really good ideas just are in the vine.

ED HOWARD: Thank you and Simon, in keeping with what Gail was talking about in the way of scoring, how long did it take to realize some of the savings that you were describing in the elements that are in the reports?

SIMON STEVENS: Ed, I would say there are kind of two components, about three components for that in fact.

One is the time it takes to go through the learning process, make mistakes, stop doing stuff that doesn't work, scale stuff that does, and in the case say of the approach to supporting seniors with multiple chronic conditions in Medicare - the Evercare approach - that has taken about 20 years. I mean, that was a program developed by two nurses and it's kind of been refined over time. So, there was clearly a kind of learning curve that you go through.

Secondly then there is the question of once you've found the answer, as it were, how quickly can you get that

diffused? And I completely agree with Gail's points about the fact that too often there is a big gap inside traditional Medicare in terms of getting those things rolled out.

And then a third piece is some of the administrative savings I was talking about, in the sense they are yet to be realized because they only occur when everybody inside the health care system is acting in concert; no individual actor can drive those changes by themselves and so you get this kind of network benefit, this positive externality when everybody is doing it, and that is what we need the regulatory framework to encourage.

ED HOWARD: Gail do you want to comment on that?

GAIL WILENSKY: I want to comment on Simon's statement that having the flexibility to make midcourse corrections was very important and to plea to all of those of you in the room who work for members of Congress to have them consider providing more discretionary authority to the CMS administrator.

I mean, what frequently happens is when you discover that there is something wrong with the idea that seemed perfectly good on paper, it takes forever to get the change in place because there is so little discretionary authority that is granted to the administration. I find it mysterious that there is consideration being given of providing complete pricing and reimbursement authority to a national board and

almost no discretionary authority given to the agency that runs the program. Hopefully we can increase that just a little.

ED HOWARD: Thank you and Janet, I wanted to just clarify what I think is a small point. In one of your slides, you talked about employee centric subsidy allocations, and I wonder if you might translate that into terms that we might all understand?

JANET MARCHIBRODA: Sure. What I meant by that was really focusing on employee centered investments. For example, offering one option that is no contribution for employees and looking at some of the per person pricing for dependents as opposed to family, all the while preserving access and choice, also some of the things that we have done are around cash, providing cash back if one opts for no coverage.

ED HOWARD: And the billion dollars in savings that you talked about are cumulative over a number of years, does that sound right? I'm sorry I didn't mean to spring that on you but –

JANET MARCHIBRODA: [Laughter] That number was actually over 2004 through … let me just double check. I want to make sure I get the right numbers here, over the last four years.

ED HOWARD: Okay, very good. We have a number of green cards and we will try to get to as many of them as we can. On the one hand, the questioner writes, Mr. Stevens has presented a detailed list of proven strategies. On the other hand, Gail Wilensky accurately points out that CBO won't necessarily score any savings from these strategies, so how are we supposed to bridge these two perspectives?

GAIL WILENSKY: CBO wins. [Laughter]

ED HOWARD: Anybody else? [Laughter]

LEN NICHOLS: CBO wins and everybody cries and then we go back. I think the way to maybe think about it is it sort of falls into that realm of what we've all been talking about and that is stuff we know we ought to do and what's great about Simon's examples and Janet's too, is that they have proven the concept here, but what we haven't proven is sort of will it work anywhere else but where it was done?

Is there something truly unique about those IBMers and/or the United enrollees, and can you take it outside the confines of people who have already learned the mistakes and that sort of stuff, so that's what pilots are about.

The way I would think about the question from a policy point of view is in my view you want to build in to the legislation all the stuff you want to do and/or discretion to do it, and that is actually better, because then you let them have a little bit more freedom on the

ground to sequence things in CMS and/or HHS and/or the private sector.

But you also need to think about a kind of what I am going to call a fail safe and that is as Gail said what do you do if you don't succeed? And I think that does come down at some level to a commitment to the in a sense are we actually going to try to change the system or not? And it cuts both ways in a couple of really tough angles.

One is we could for example imagine a thing where we said look, we are going to put all these wonderful experiments out to flower. We believe some will work, we know some won't.

We will try to take the ones we can to scale, but if we are not on a pathway by say year six, then one might imagine a kind of policy that says we are going to reduce something, lots of ways to think about it what, the simplest thing is updates across the board maybe for a particular set of providers. What my CBOs recommend is for those who have costs above the median, so you have a kind of reduction built in, in case you don't succeed.

Now, what you could do, in fact what I would recommend you think about, is you have a decision point and that decision point could inject new revenue, it could inject dialing down the benefit package, it could inject dialing down the subsidies. You could move a lot of variables, you

could move variables in year six just like you can move them in year one. And you may want to think about in essence forcing a set of decisions to be made if you have agreed upon criteria by which those things will be judged.

But in the short run there is no question. CBO would take Simon's examples and say very nice; let's prove it can be disseminated before they would give us a dollar, I think would be fair to say.

ED HOWARD: Simon?

SIMON STEVENS: I think that's absolutely fair. I think the point though is that we are trying to solve the two problems here, aren't we, and I think both Gail and Len have talked about that. The fact is that CBO in a sense would be indifferent to whether Janet's IBM medical cost trend was 4-percent or 8-percent next year, but that would make a heck of a difference to the workers at IBM. And more generally if you think about the economic squeeze on middle class families over the course of the last decade or so, that has been driven by out-of-control health care costs.

Those are not costs that show up through a CBO spreadsheet, which is a different exercise around government math, but we know, according to figures from the Kaiser Family Foundation that whereas workers earnings have gone up by 34-percent over the course of the last decade or so, health care costs have more than doubled, 119-percent. Doing

something about that problem is independently an important thing to do, almost regardless of the way the CBO math works for the coverage expansions.

ED HOWARD: Good point.

GAIL WILENSKY: And of course that is true, but it is not what most of the people in this room are worrying about at the moment, which is how exactly are we going to come up with the $1 to $1.5 trillion that we need in order to finance expansions and what kind of a mix do we use in terms of revenue, reduced payments and delivery system reform.

My plea is to make sure that we are cognizant that some of the ways we may find to increase revenue from reduced payments may make reforming the delivery system that much harder and that really is the concern that I have and while I can imagine Len's CEO saying if you have above the median costs, you reduce the update. That is because those guys are all in large systems but most physicians unfortunately are in their groups of three or four right now and it's much harder to be able to do that.

I don't, again I don't want to say that we can't and shouldn't drive these delivery system reforms. I am a little concerned about how reliable that is likely to be in the first five, eight years in terms of financing coverage. I don't think that congress or the administration probably for

that matter is thinking about that kind of delay in order to expand coverage.

So, it means having either staged expansions or being very clear that if we start more heavily on the financing coverage, we had better get to that second part because we are only going to exacerbate the problem that we have in terms of not having sustainable spending.

LEN NICHOLS: If I could just clarify one moment, well Gail is right, I got three of my CEOs who are leaders of integrated delivery systems. I also have two big heterogeneous hospital systems, Ascension and Catholic West, and they have some of the best and some of the worst. It is America.

And they are willing to do this because they know that if we fail this time to get a comprehensive agreement on how to move forward, they are very, very sure we are going to see pretty awful stuff down the road, that is to say price controls, because we know how to do that, and they would rather have this be part of the comprehensive agreement.

Now, it’s interesting, because I actually give them higher marks than everybody else, because they are putting a greater risk on the table. Their point of view about the fail safe is look, you have to make it clear that you intend to do this, there is no going back, so that they can use that

as if you will a disciplining device and/or a motivational tool.

You know, my favorite movie is “Red October.” Right? Where Ramius, the guy who got the, you know what I’m talking about, “Red October” the summary of the movie, he gets plans for the boat, the boat was designed to start a nuclear war because it was designed to be completely silent.

He gets the plans for the boat, and he hand picks the officers to go with him, volunteers to be the captain, takes the ship out, tells the Polit Bureau on the day they disembark he intends to defect, so that the Russian Navy will be sent after him so the American Navy will come and wonder what all the fuss is about so he can surrender before he gets sunk.

So, the first night at sea he tells his officers of the Polit Bureau letter, and the young junior officer with the most testosterone gets the most scared and says oh my God, you’ve signed our death warrant. They are going to kill us. And Ramius of course sipped his tea and said “When Cortez reached the new world, he burned his ships. As a consequence, his men were highly motivated.” [Laughter]

The point is if you have the fail safe in the legislation and you make the commitment to do the experiments and the support, let’s be clear, a lot of what we are talking

about is let’s do some evidence based regulation here sports fans, in addition to evidence based care.

But if you do all that, then they claim we can then, we can turn the ship, we can in fact, we can make this work. If you don’t make it clear, we will scurry around and hide under the fee-for-service rocks forever.

ED HOWARD: In the hunt for ways to avoid red ink [laughter], a questioner suggests that employees of big companies, particularly progressive ones, may not be as representative of the U.S. population as we need them to be, because they are perhaps better health risks or are better organized and the questioner asked to what degree are the numbers from employer programs applicable to the general population?

And I might add to that question for Simon, the numbers that are generated by your general population can’t get 70 million exceptional people I don’t guess, [laughter] compatible with the kinds of findings in IBM and Safeway and some of the other programs we’ve been hearing about.

SIMON STEVENS: Yes. So, I’m reminded of the “Hunt for the Red October”, there was another piece of the story that Len didn’t tell us, which was that I think Sean Connery actually shot the crew member who he found disagreeable.

LEN NICHOLS: Oh no, KGB, KGB, he shot the KGB, let’s be clear.

SIMON STEVENS: No, there was a new guy assigned to the team who wasn't hand picked who showed up for duty and they realized it all went terribly wrong so I think he got shot in a canteen didn't he? [Laughter]

LEN NICHOLS: He slipped on his tea. [Laughter]

ED HOWARD: And remember, you get the cultural education that you didn't get in high school right here. [Laughter]

SIMON STEVENS: Okay, so back to the question at hand, what we found is that for those employers who have been using these kind of combination of programs that we have the privilege of working on with Janet and with IBM, over the course of four years, their trend has been several percentage points below that of the national average. The last two years, it's been about 4-percent compared with 6- to 8-percent more generally. So that does appear to be a consistent pattern that as these programs mature in these employee populations, then you get an impact.

But the other thing we found frankly is that you can't do them as a series of magic bullets. You've actually got to do them in combination, and so just to give you kind of one concrete example of that, there are 23 million people with diabetes, 54 million people who are pre-diabetic. At the moment, we know that their services are often being very

poorly organized and coordinated: about a million people a year die from complications from diabetes.

So what we have done with some of the progressive employers is create a diabetes health plan, and what that has done is combine specific screening and preventive programs with a benefit design that lowers costs for employees around their diabetic medications and supplies; a network of high quality providers who've demonstrated high care standards for diabetes; and then rewards for compliance for the individual employees up to $500 a year.

And we think this combination of things, kind of - evidence based standards, taking some of the costs out of the system for employees for their concordance, their compliance, together with access to really high quality providers - it's that sort of combination of stuff that's probably going to make a difference.

ED HOWARD: And it works with big employers and small employers.

SIMON STEVENS: Yes.

JANET MARCHIBRODA: Just to add to that, so we weren't always there and there were significant improvements over time and a reduction in risky behaviors and the like, but in your packet you can see other examples. In my former life as well as here at IBM, there are a number of Medicaid programs that have made progress as well and I think we have

got one example of a terrific program down in North Carolina where through care coordination we have seen improvements in quality and reductions in cost, so lots of good examples with different populations.

ED HOWARD: I've got a more specific question that was raised in two separate cards that were submitted in advance, and they both have to do with end of life care. One asks about the quality and cost implications of palliative care for patients with serious chronic illness as distinct from end of life care.

The other asks whether there are on the part of the panel indications of a stronger emphasis on end of life care, public education as a means to enhance quality while decreasing costs. I must say, we have touched on these questions in other Alliance programs. In defense of our panel we were not expecting them to be experts on end of life care.

GAIL WILENSKY: Actually, like Simon, if you know it, to indicate whether there are any specific programs that United Health Care has put together. In past instances, while hospice has been a very popular program for the relatively limited number of people who avail themselves of the hospice program usually very, very close to their end point of their terminal illness, it has not been much of a cost saver, but it has been.

Because we, for the most part, still follow the first model of hospice which is thinking about it as an end point and most likely to be cancer related treatment of disease rather than a gradual decline of a chronic disease that ultimately ends in death, and I don't know what the cost experience or patient satisfaction experience is, if that has been used.

LEN NICHOLS: Simon, do you want to talk about what you know? Aetna is doing one I know about.

SIMON STEVENS: I am sure there are many programs. What I would say is that I think what we know is that, at the moment, people's own preferences are not being made to stick in the way health care is provided at this time in people's lives. Most people say they would like to die at home. Most people actually die in hospitals.

We know that the hospice program on average, the median length of time somebody is in the hospice program is 20 days, so about three weeks, whereas in fact the point of which people's decline where the costs begin to have an impact could occur as much as seven months before the point at which they die.

So, we have got to get several things right. One, we have got to get more palliative care consultants in hospitals. Two, we have got to get more serious about advanced directives, people having the opportunity to set

their preferences out, discuss them with their families and then ensure they stick in the way care is provided.

And three, we probably need some programs that kick in ahead of formal hospice so that people can get some of that support in their own homes, working with their teams of physicians before having to make this binary choice about whether to move into a palliative and a hospice program or whether to stick with curative care. We do those three things and other things as well. I think we can get a system that is more aligned to the dignity and the preferences that individuals themselves have.

LEN NICHOLS: Ed, I was just going to say for the audience and I agree, I'm not an expert by any stretch, but I would recommend you look at the Center for the Advancement of Palliative Care, just type in Google. There's a woman who runs that called Diane Meyer. Diane just won a McArthur and she also just got a fellowship.

She is coming down to Washington starting in October I think. We would like to move her here tomorrow. But anyway, go to their website, you will find a fair bit of literature on what palliative care has and can do, and there are some pretty interesting both in particular family satisfaction but also some real system savings, as Simon said mostly because most people really, given all the choices, given appropriate conversation, what Diane really does is

teach people how to talk to families. People choose the least invasive options.

GAIL WILENSKY: Just as a point of information, in the past, Medicare has been spending about 28-percent of its dollars on people during the last 12 months of their lifetime. Now, it would be expected over time as the number on Medicare begins to grow substantially which has, as you know, not happened yet.

But starting after 2010, will begin to happen with more vigor. That number ought to be going down because you will be having a lot of people on the program but only some of whom will be in that last period, but it's been a pretty constant number to date interestingly, actual, in its constancy.

ED HOWARD: Thank you. Harking back Gail to an earlier pronouncement that you made, in your experience do CBO estimates tend to be accurate as well as final? [Laughter]

GAIL WILENSKY: Well, CBO makes errors like everybody else, and the more complex the change, the more likely it is that CBO will make a big mistake. Two recent ones, for people who have been around for the last dozen years, might remember is the Balanced Budget Act and Part D Medicare. The estimate for the Balanced Budget Act is that Medicare would

be slowed from about 8-percent spending to 5.8-percent growth.

In fact, spending grew at about 1.5-percent the first year, actually was a slight decline, 213 to 212 billion the second year, a very small decline the third year and then it was off back to where people expected in part because Congress intervened and passed two or three different bills to give back some of the money.

My own personal view on that is as much of what we were seeing is that the physicians and hospitals were scared out of their mind by the aggressive Department of Justice and Inspector General program on Medicare fraud, and they froze in place, and that, way more than missing the BBA estimate, is why there was such a dramatic decline.

In Part D Medicare, there was a big battle about whether it was going to be $540 billion in spending or $396 billion, something like that, in spending, but they were both wrong. Spending was about 40-percent, cumulatively less than what was predicted. It showed the aggressive impact of competitive behavior during those first couple of years of Part D. Whether it will continue is something we will have to wait and figure out.

But more often than not, CBO has underestimated the cost of new programs, but they certainly have underestimated the savings of big programs but if you don’t have a CBO, then

you put yourself in jeopardy of doing what happened when Medicare was passed.

When the estimate was that Part B and Part A in 1991 was going to be about $10 billion and it was off by a factor of 9 or 10 [laughter], I think Medicaid didn't even show up on the radar screen because they assumed it would be like the Kerr Mills Bill and none of the states would take it so they didn't even bother making an estimate and these are just huge, enormous programs.

So, while they tend to be cynics and skeptics because everybody promises savings, and to their jaundicized, precious few deliver, it's hard to run a program not having that with people who use the best judgment they can.

ED HOWARD: By the way, we are going to continue this conversation in a slightly different direction in a program we are planning for I think it's the 31st of this month in which we will also talk about some revenue sources and although you can't, or at least we haven't been able to, get folks currently at CBO to let anyone know what's inside their black box, we will have at least one former congressional budget expert as part of that panel and we can have a further conversation on that aspect of it.

I have got a question for you Simon, and what are United's views about rating providers per encounter, the way I do with Matrix or Amazon? [Laughter] Or Craigslist?

SIMON STEVENS: Yes, so I think there are a variety of places you can go on the internet and begin to do that, so that's kind of, that's out there. I think our take would be that probably the biggest gains are going to be had from trying to start by looking at the differences in quality, clinical quality, and the differences in resource use that exists to care providers and then you can ally that with the kind of consumer opinion that you were talking about.

Certainly what we found is when you do that, these well documented variations that are said to exist in the research literature, they do it turns out exist in practice, and then if you make that information available to patients, it can influence their choices.

And so for example for the group of cardiac surgeons and cardiologists who we have identified as being in the top performing tier, patients who are making choices together there are seeing a 19-percent lower rate of re-dos for coronary artery bypass grafting, 59-percent lower cardiology complication rates, same kind of experience in other services, musculoskeletal, spinal surgeons 45-percent fewer repeat operations, and so on.

So, the fact is, these data are out there, being more transparent about them in a way that is user friendly for patients and for consumers would probably be one of the

single, most transformative ways of unleashing more value out of the health care system.

And certainly we believe that, whereas the individual efforts of particular payers has been necessary to kick start this process, there would be huge gains from being able to pool those data across payers including the CMS Medicare data, so that you actually have a process that was overseen by physicians on a scientific basis but which kind of drew back the veil so that the average user of the health care system would have the same kinds of inside knowledge that all of the professionals working in it already have.

ED HOWARD: I've got a question for you, Janet. The questioner notes that the American Recovery Act is going to provide incentives for health information technology but IT is not highlighted particularly in reform legislation drafts, and the question is what role will Health IT have in helping promote savings by making patient health care more effective and more efficient in rolling out reforms?

JANET MARCHIBRODA: Well, first of all I'm glad you asked, having spend the last eight years of my life focusing on this issue, I'm really excited about the investment, the significant unprecedented investments made in Health IT through the Recovery Act because they actually create the foundation upon which we can see true health care reform.

And we, as you well know, we largely reward doing more as opposed to doing well, or doing better. And if implemented effectively and from what I can tell from some of the early deliberations by the FACA, the Federal Advisory Committees that have put forth around what constitutes meaningful use of health information technology, we could really use this as a foundation.

So if you look at June 16th, the Health IT committee put out some guidance of which HHS and CMS will have the final word by the end of this year around what would happen.

There are a number of performance measures, process and outcome measures around delivering better health care that will be hard to do without not only the use of applications but more importantly connecting, whether it's across laboratories, doctors' offices, pharmacies, hospitals, specialists, and the like.

So it plays a critical role and I think we got a great shot in the arm with the Recovery Act, if implemented effectively we can actually create the foundation for all of this to happen.

ED HOWARD: And do you agree with the premise that the reform legislation is not particularly focusing on IT?

JANET MARCHIBRODA: I think what it does, I mean the big, so if you look across the country, the states and the regions that are trying to or even nationally, trying to

exchange information electronically, we have had trouble getting there because we don't have a sustainable business model for the exchange of data.

And so, moving to our different delivery models that actually reward care coordination or delivering better quality care will actually help further reduce costs associated with those IT investments.

ED HOWARD: And could I ask you, Simon, what role, if any, the availability of IT played in getting you to the numbers that you presented in the report?

SIMON STEVENS: Yes, but not so on the clinical numbers.

ED HOWARD: Yes.

SIMON STEVENS: We said there are a set of foundational changes, these CORE standards and various other standards that need to be mandated across the system, they are foundational for doing some of the other things that should then occur.

Now, the investments made in Health IT through ARRA, they are a great start, but by itself that doesn't get you the whole way, so there is also a regulatory or phasing piece to this so that we've got that kind of single set of interoperable transactional standards right across the health care system.

ED HOWARD: By the way, let me just say a couple of things here as we draw to the last 10 or 15 minutes, one is that I have a lot more green cards than I am going to get a chance to get to in the course of that time, so if you want to get to a microphone to make sure your question gets asked, that is the sure way.

And second, as we get to this stage, I would ask you to help us to improve these programs by filling out the blue evaluation form and giving us some suggestions on how we can make those improvements.

I have got a question here that goes back to the estimate of an increase in spending associated with reform of $100 to $125 billion a year. The questioner asks, is this saying that as soon as people get coverage, they will show up at the doctor's office or in hospitals for care? And if so, do we have enough docs and hospital capacity for these out of the woodwork care demands?

GAIL WILENSKY: The statistics we have indicate that people without health insurance coverage use about 50-percent of the care as people who do have health insurance coverage and that is true all along the illness spectrum, even for the very sick, they use about half of the health care coverage.

Now, that is not to suggest that the insured sick are using necessarily the right amount of health care coverage but it does indicate that until we have some kind of reform

in the delivery system, we ought to expect a big bump up in the attempted use of people who have not been covered when they get coverage.

The question about whether we have the capacity is harder to answer because much of it depends on what exactly their needs are, where they live, and where they go for their care. In the short term, there is certainly likely to be some dislocations, Massachusetts has found pressure on their primary care physicians.

Although when I was up spending a day at the Kennedy School, the indication I had from them was if it wasn't a particular doc that you wanted to see, but getting to see a doc, that was less of a problem with two exceptions, two very low supply counties in Massachusetts.

Otherwise, that was not as much of a question, but we know we have serious distributional issues with regard to specialty mix and with regard to institutional capacity. There has been a big debate as the people here may know about whether we are going into an impending physician shortage. My view is that largely depends on what kind of a delivery system we assume. If we assume we continue delivering health care as we have been, then there is no question we have a physician shortage.

My second comment would be why would we ever want to do that? [Laughter] We know we have unsustainable spending

and inappropriate clinical outcomes so it's trickier when you think about driving to a different delivery model but in the short term while we are trying to get from here to there, there are likely to be dislocations while we try to figure out whether we want to make more use of nurse practitioners, how we can encourage more physicians to go into primary care, but at the same time recognize that we still have this huge number of physician populations that is specialty trained and they are not going to go away any time soon.

ED HOWARD: And I guess it's worth noting that in Len Nichols' diagram of the virtuous circle, there was a payment reform element that presumably would address primary care availability as part of its incentives.

LEN NICHOLS: Oh absolutely and I would go back to Janet's point about this whole notion of what I will call team based production of primary care and medical home, there are lots of ways to design that. Just think a little bit about the algebra here. The uninsured are roughly 16-percent of the population.

We need 8-percent more care roughly. I mean, I'd say a little bit less than that since they are younger and so forth, so it's probably more like 6, so we need 6-percent more capacity if we were able, and by the way we outnumber them six to one, so if each of us reduced our visits by one, there is plenty of room, here.

The trick is, how do we enable primary care docs in particular to make a living with fewer visits? And the answer is payment reform, so it does all kind of angle together. It cannot be done on day one. I will also point out, interestingly to me, even in the house the bills are actually talking about 2013 as a beginning date. Frankly I think that's for scoring purposes but I will just note that is the default option.

More than likely if we did pass a bill this year, even if we really seriously wanted to we couldn't start exchanges before the middle of 2011 or probably closer to 2012 and you might have heard this rumor, not everybody is going to show up on the first day.

It's going to take awhile to get everything going so it probably is going to be a full year after we begin enrollment before we have something close to the capacity demands that are in the algebra, but they are real and we are not going to have payment reform done by then so we are going to have some bumps, no question.

ED HOWARD: I've got a question for Janet Marchibroda, talking about the IBM experience, wondering how you assessed or verified the fact that beneficiaries were active in participating in wellness programs for purposes of your incentive programs and how did you measure these things?

JANET MARCHIBRODA: We actually have online tools for employees and so when you enroll in an ongoing basis it is performed through an online personal management tool and in terms of the calculation of the savings, I would have to get back with you on the specifics of that question.

ED HOWARD: We have got a couple of related questions. One is directed to you, Simon. Do you happen to know the costs if any incurred by United in educating patients and providers on the use of new technologies?

SIMON STEVENS: No. [Laughter]

ED HOWARD: In general, and this is for anybody, the cost of education obviously is an aspect of this, as Len said not everybody is going to show up immediately and somebody has to show them the advantages thereof, are the costs of educating the public on use of say a health exchange as well as the system itself or the new H.IT being figured into the overall cost of health care reform? Or any of the estimates that we have been discussing of the net savings?

GAIL WILENSKY: I assume on a relative scale they are probably sufficiently small that they are not laid out but it is a fair enough question. It’s harder for me to answer the health IT or the exchange portion.

But if you think about the health education more broadly in terms of diabetes or other preventive services, for any group that is at risk financially or otherwise going

to be held accountable for the health of the individual, they have a very powerful incentive to engage in education techniques.

And that is really why, among the many reasons to reform the payment system is you want to allow delivery systems to be able to spend some of their money for what they regard as effective prevention or other interventions rather than to be tied to the billing system that we use now in say the RVRVS.

ED HOWARD: That actually is a nice segue to a question that is intriguing because it actually carries with it a suggestion that CBO might score. If most chronic diseases begin by age 40, and the behavior change necessary to successfully modify disease progression takes 10-20 years. Why do we pay for a welcome to Medicare exam at age 65 and call that prevention? Why not move the welcome to Medicare exam to age 40, score it for future savings and truly call it prevention?

GAIL WILENSKY: Well, the problem I think that Medicare or CBO would say is if that’s all you do, you are not likely to see much impact. You really need to bring people into a care system so that if they have diabetes or congestive heart failure or hypertension or all three of those, their care occurs in some kind of coordinated way.

There is indication as again I think most of you probably know, that people who are not insured until Medicare are higher users at least initially when they come on the program, some of that being pent up demand and probably some of that reflecting the use of health care that could have been avoided with different kinds of preventive behavior earlier.

ED HOWARD: That actually, there is a serious question embedded in that for the listly worded question that was submitted, and it relates to what several of you have suggested is the very long lead time some of these steps are going to take to get embedded in the system, whether it's provider education, patient education, the spread of technology and a different culture so that providers function more like they do in El Paso than they do in Megalla.

When you combine that with the 10 year window that CBO is bound by statute to apply to scoring, it shows you some of the difficulty. Are many of the steps that you've been talking about likely to produce substantially greater savings in say the second 10 years than they are in the scorable first 10 years?

GAIL WILENSKY: Well, in terms of actually achieving the reform of the delivery system, I wouldn't be surprised if a lot of the activity goes on in years 11 to 15 in addition to years 6-10. I mean, I would regard that as probably the

most active period. It will take several years to decide what you want to do and get it going and up and running.

I talk to people who have put together diabetes care models and tried to look at the issue of how might you get CBO to be willing to score savings that really have to go with long term behavior modification, and it's really tough.

When you start looking out 15, 20 years, the number of variables that start to change are so great that you can talk about them in terms of where you want to go, but if you're really trying to define them in terms of a budget window, it would just become extremely difficult.

We don't do all that role for 10 years, but we frequently don't do all that well for one to two years. I think trying to go and get into the two decade region would tell you the magnitude of the direction of change you expect, but it would be very difficult to get anybody to seriously be comfortable with the actual numbers would be my guess.

SIMON STEVENS: I agree with Gail. I think nevertheless there are some things that could be done that would have an impact very quickly. For example, we think that too much of the fraud and abuse process that currently goes on is retrospective. It's after the event.

There are some technologies now available to score the likelihood that a claim inside Medicare is fraudulent prospectively, and then investigate it, rather than paying it

out and trying to get it back later. There are potentially significant dollars associated with that.

Similarly if you look at what's happened to radiology spending inside fee for service Medicare. Between 2000 and 2006, radiology spending rose from $7 billion to $14 billion. There are some pretty basic appropriateness review processes that could at least slow the growth, if not have an impact on current spending.

But over and above that, I think as Gail says, some of these kind of more interesting approaches like what United and IBM are doing jointly down in Arizona with a group of primary care physicians, the patient centered medical home, the truth is we don't know the answer right now.

We have got what we think is a matrix of kind of six different variables that are likely to be influenced by this process with a target impact that cashes out to an expected gross savings contribution for that. We will know more in 12 months, in 24 months, in 36 months. There are these kind of real world pilots, but I think for right now, it's hard to be definitive.

LEN NICHOLS: I would just add it's important to remember we did not make CBO the 101st senator. They don't have a vote. Their job and I think we all support their job, in fact I will just say they are very smart people. I know Doug Elvendorf very well. You wouldn't want anything but a

group of people like that doing the job they are doing. They are there to provide intellectual rigor to what we do and do not know.

You can argue about this or that and you can argue about whether they took my personal paper seriously enough, but nevertheless, [laughter] they do their job. Their job is to convey the best guess about the implications of choices. The choices are still made by the people who got elected. So, what you are looking at here is a situation where they don't have detail power.

They have the power to say this is what we think it's going to cost and you, the ones who've been chosen by the people, have to decide if it's worth it, and that's really, I mean, you've got to remember that.

ED HOWARD: Okay. Yes, go right ahead. Identify yourself if you would.

ALDENA NASH: My name is Aldena Nash. I'm here from Washington, D.C., and expert in infection control, now that this briefing is almost over, I just want to say thank you to the Alliance. This is an incredibly comprehensive and valuable source of information and also the supporters of this case, United Health Foundation.

And I think after hearing all of this the question is not how can quality improvement reduce health care costs, but how much it can reduce health care costs. Because

considering what quality is and that we are talking about health care and not management of sickness or illness, I think there is no question that improvement of quality will reduce costs but my main point is just thank you.

ED HOWARD: Well, what a wonderful way to end [laughter] and the check is [laughter] with Deanna over in our staff. It is actually, actually we have another questioner back there. It had better be complimentary!

KRISTEN BUKOWSKI: Okay, well, I'll try here, but my name is Kristen Bukowski and I'm with the American Society of Radiation Oncology and I'm also currently a medical student doing an internship here this summer.

So I guess my question is the idea of the physician shortage came up, I was wondering basically we have a couple of issues going on that are really going to exacerbate the problem. As we know, the baby boomers are getting older and they are going to need health care very soon as well as just an overall aging population, because of the health care we provide, people are living longer, and currently about 25-percent of our doctors are about to retire in the next five years, just because they are close to the end of their career.

Is the government doing anything to address this situation by maybe thinking about the balance budget act and lifting the residency cap that was placed on the number of

slots we had in the country back in 1997, so hopefully preventing the devastating shortage in the next kind of decade here.

GAIL WILENSKY: Well, the residency camp is of unknown impact, given the number of immigrant physicians that we have coming into the country but I think if you see activity by the federal government, it will be much more directed. There are a few things that are as screwed up as how we reimburse for graduate medical education, at least from the point of view of this former Med Pack chair and Medicare administrator.

So, I hope that one of these days congress will get onto it but it will be far more than just thinking about the cap on residencies and the whole area about who we incent to go into what specialty, what kind of loan forgiveness programs, what kind of reimbursement systems would be designed to assist in providing the rightness of care.

It’s true we are an aging population, but if we can get physicians to act more the way they do in intermittent health care or in Kaiser’s or in the May Clinics, it is not clear we have a particular aggregate shortage of physicians.

We may well have spot shortages in some parts of the country and we certainly have specialty shortages that will occur but we need to really think about the delivery system we want going forward before we think about churning out a

lot more people that look like the people we've churned out in the past. That really doesn't make any sense.

ED HOWARD: Well, it wasn't quite as direct a compliment, but I'll take it. [Laughter] And it is a good stopping point. I wanted to thank you for sticking with a very wide ranging discussion on a very difficult topic.

Let me just do a little commercial here, we are doing a second briefing this week, on Friday, on connection between mental health, behavioral health and health care reform, and if you haven't seen that notice, you might go to our website and sign up because I think it's a very important topic.

I want to reiterate our thanks to United Health Group, for Simon and his work, and the United Health Foundation for support, Joyce Larkin and her colleagues, who helped us put together I think a very useful discussion. I will ask you to help me in thanking our panelists for an incredibly good discussion of a tough issue. [Applause]

[END RECORDING]