



# Challenges Facing the US Health Care System The 22nd Princeton Conference Report

Princeton, New Jersey ■ May 12–14, 2015

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## Introduction

The 22nd Princeton Conference examined a range of contemporary health care system changes and challenges. The conference began with a dinner talk from Professor Uwe Reinhardt about the hazards of “consumer directed” health plans and the lack of price and cost transparency. The first session on the impact of consolidation in the health care delivery system suggested robust consolidation is as much about protecting market share as seeking efficiencies. The second session analyzed workforce challenges. It highlighted historical uncertainty in predicting health care provider demand, but concluded we need to change the way we educate providers and the way we pay for it. The third session addressed the rising cost of specialty pharmaceuticals and prospects of value based pricing. Session four examined private market insurance reforms with optimism that directly engaging providers in new models of health care payment and delivery holds promise for system improvements.

The second dinner covered the role of stories and narratives in helping to educate students and the public on complex health care policies and programs. Session five explored Medicare changes coming out of the ACA with a focus on innovation and opportunities for improvement. Session six looked at trends in health care spending concluding that higher prices drive system costs and there are no systematic checks on returning to upward trends. Session seven discussed quality and persistent problems with overutilization and medical errors despite models of success. The final session was on health care politics in a divided government. People praised the bipartisan passage of the Medicare Sustained Growth Rate (SGR) bill, or “doc fix,” but were generally skeptical that this success would launch further bipartisan cooperation. This summary pamphlet covers main points made by presenters on each of these topics and incorporates insight from the audience.

## Dinner Night One: Consumer Directed Health Plans, a Cruel Hoax

Uwe Reinhardt kicked off the conference dinner covering the rising trend of consumer directed health plans (CDHP), or high deductible health plans with narrow networks. He contrasted a single payer system covering everyone, to a private system covering those who can afford the costs. Reinhardt suggested that CDHP and limited next plans can be a cruel hoax because they are absolutely linked to the ability to pay. These plans ration health care by income through high deductibles, co-insurance and copayments and require patients to pay high rates to use care provided by out of network providers. These approaches ultimately undermines the goals of Obamacare by forcing people to forgo care because the out-of-pocket costs are so high that it is almost the same as being uninsured.

He provided an example of a woman who took her husband to their family physician after being hit in the face by a baseball. She knew that physician was covered under her health plan, but because the doctor was practicing in an out-of-network hospital that day, the visit resulted in an emergency visit that was not fully covered. In fact, her insurance only covered \$13,100 of the \$90,000 bill. How was she supposed to know her in-network doctor practicing in an out-of-network hospital was not covered? How is this “empowering” the consumer? Another example he provided was “43% in Texas people reported avoiding health care because of cost- this is rationing of health care. We should be honest about it; this is what consumer directed health care is.”

Additionally, Reinhardt spoke about asking 10+ hospitals the price for a colonoscopy and the fact that not one could tell him. He said, “looking at CDHPs from an economic perspective, how can you attribute outcomes (q’s) to costs (p’s) when there are a million p’s and a gazillion q’s?!” Why have so little been done to make price and quality visible? We should be outraged about this.

## Session i: Impact of Consolidation in the Health Care Delivery and Financing Systems

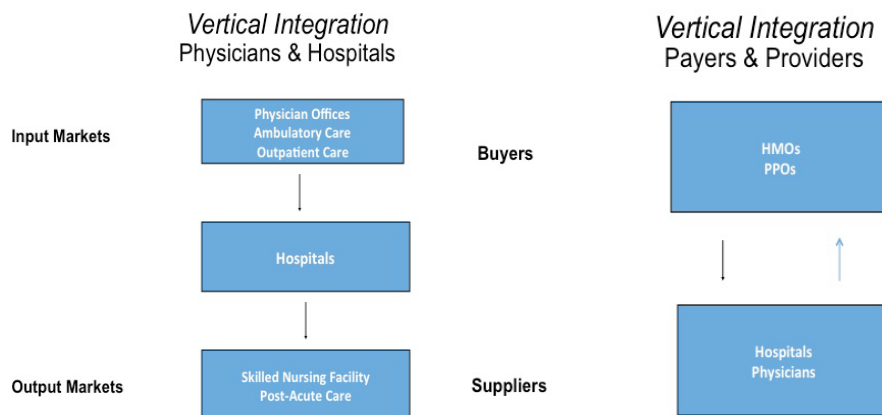
While consolidation of the health care delivery system continues at a strong pace, it is more likely that these actions protect market share than gain efficiencies in care delivery. While we have had 24 months of basically flat prices, returning to rapid cost growth is a concern. Consequently, higher prices have been found to correlate with provider concentration. Evidence suggests that prices tend to increase with mergers, but there is considerable regional variation based on market saturation. Robert Berenson cited aggregate hospital payment-to-cost ratios for private payers increased from about 115% in 2000 to 149% in 2012. Stuart Altman argued that as long as revenue is available for higher spending without constraint, then the range of providers will continue to charge what they can.

### *Robert Berenson (Moderator)*

Robert Berenson provided an overview of the issue of consolidation with a focus on the impact on prices, quoting a well-known paper by Uwe Reinhardt, Gerry Anderson and others, "It's the prices, stupid!" Prices are significantly correlated with market leverage above everything else, and the resultant variations of negotiated hospital and physician payment rates are huge. Berenson pointed out that commentators described the late 1990's as featuring a "stampede" to hospital consolidation and the last few years as having a "merger frenzy" of hospitals, thereby raising the question of whether there were any more possible mergers for antitrust policy to object to. Yet, the evidence shows these provider consolidations so far have not improved performance, but they have raised prices much faster than underlying cost growth.

### *Lawton Robert Burns*

Lawton Burns covered the types, extent and drivers of consolidations, and explained their impact on quality, cost, price, profitability, and alignment. The inputs and outputs of vertical integration between physicians and hospitals and payers and providers are shown in charts below:



For vertical integration between hospitals and physicians, the types of relationships consolidations can yield are:

- Complete purchase of hospital medical staff
- Alliances and allies between stakeholders (ie. Physician-Hospital Organizations, PHOs, or Management Services Organizations, MSOs)
- Hierarchical relationships among hospitals and physicians

Alliance relationship models peaked in the 1990's, but yielded few successful models of efficient collaboration in large part due to their inability to manage risk. They had little impact on physician alignment and garnered no cost or quality improvement. Today hospitals are employing more physicians, but the extent of these consolidations depends on whom you ask. In 2013, Credit Suisse estimated about 2/3rd of physicians were employed by hospitals, while in the same year the AHA estimated only about 1/7th of physicians were employed by hospitals. Ultimately physicians and hospitals have few overlapping goals, and the current research on physician-hospital integration shows little evidence of improved efficiency.

To date, payer provider integration similarly shows limited traction. One of the few studies in this area found 10 out of 14 hospital sponsored health plans observed had higher average costs with no meaningful difference in quality. Burns concluded that at this point we still do not have positive savings or increased quality findings for vertical integration structures created by consolidations.

### *Richard Scheffler*

Richard Scheffler examined the impact of increased consolidation in "Cover California" the state's ACA market place. Cover California was successful in covering 1.4 million enrollees. A total of 30 plans applied, but just 11 were selected to participate. The top 4 plans have 90 percent of the state's enrollment. While early implementation saw reduced premiums, there was significant variation across the state, and higher levels of consolidation were associated with higher, not lower premiums.

The Cover California model set criteria for participating insurance carriers to ensure they met the cost-sharing and benefit structure requirements of the qualifying health plans in California. The state established the Kaiser Small Group HMO 30 as the benchmark plan in California and negotiated with insurers on premiums, provider networks, and customer service standards. During open enrollment in 2014, more than 43% of eligible consumers signed up, representing almost 20% of total marketplace enrollment nationwide. At that point, the top four insurers, Anthem, Blue Shield, Health Net, and Kaiser, had 93% of the market share.

With only a few dominant insurers, Scheffler and his team investigated the impact of provider and health plan market power on premiums. They found that premiums rose with increased medical group and hospital concentration, and that this explained about 80% of the premium variation in the market. Based on these estimates, a 20% increase in medical group market concentration would result in an additional \$13.3 million in total premiums statewide. Meanwhile, a 20% increase in hospital market concentration is associated with an additional \$23 million in total premiums. Hence the conclusion that consolidation leads to higher prices in saturated markets.

### *Sherry Glied*

Sherry Glied discussed the challenges of consolidation and its potential impact on the health care delivery system. The effectiveness of vertical integration is variable and contingent on the technology of contracting, monitoring, and 3rd party payers. Policy options to facilitate efficiency include reinforcing competition through anti-trust enforcement, increasing transparency, and narrowing the anti-competitive rules. Alternatively regulation could be used to place limits on negotiated rates or to institute all-payer rate setting, though politically this would be challenging.

Glied pointed to Maryland's all-payer rate setting as a model of mixed success. While there is some evidence of cost

containment, the state still has one of the highest rates of per capita health care spending in the country (\$7,492 per capita). This supports the prior conclusion that the success of consolidation is dependent on physician and hospital saturation in the marketplace. She concluded that competition is not suitable everywhere, and for true success, regulations and policies around consolidation should be tailored specifically at the state and even county level.

### *David Vandewater*

Hospitals from their perspective are stretched thin, experiencing decreasing margins and consolidation done correctly is the best hope for cost containment. Hospital revenue from the government has been flat to negative, with Medicare margins at an all-time low. Hospitals are forced to try and recoup government underpayment with increased revenue from commercial insurers, but this is becoming increasingly difficult.

Coupled with lower revenue are high costs, particularly salary and benefits, which account for 40% of hospital expenditures. Annual salary increases as low as two to three percent could put some hospitals out of business. By comparison, hospitals in other countries pay about ½ to ¼ of what U.S. hospitals pay for medical supplies. In effect, U.S. hospitals are paying a higher portion of the cost to develop medical devices and drugs, which only subsidizes their use in other countries.

One of the only solutions to combat this fiscal pressure is for hospitals to consolidate. Vandewater argued that theoretically with the right fine tuning of routines and procedures in consolidations, they could improve quality, sustain investment in health IT, reduce excess capacity, and increase competition.

### *Discussion*

Panelists identified vertical integration as the most promising option for coordinating care and achieving efficiencies. If we are moving towards global payments with compensation for quality we are going to have to be more advanced in quality measures than we are today. It was suggested that there can be competition on price and quality if caps are set on how much cost could grow for every provider. Massachusetts sets an example by at least loosely targeting increases to the growth of the state economy. There are still concerns about cost growth. One participant stated that hospitals ability to pay drives the cost of pharmaceuticals and devices, and that there are currently no real restraints. There was support for more state level analysis. For example, California is testing the viability of narrow networks and marketplaces competing on price. The state has some 2 million in ACOs not counting Kaiser and could serve as an example or a cautionary tale for the nation. There was also the more skeptical suggestion that all segments of the market justify why it isn't their problem and how "others" should change.

## **Session ii: How do we get a health care workforce for the 21st century?**

It is extremely difficult to predict health care workforce needs. Historical predictions have even been directionally wrong. That said, there was agreement amongst panelists that we need to provide more resources for training and upgrade education to meet the needs of a changing health care delivery system. This includes a greater focus on teamwork, the effective incorporation of information technology, and attention to culturally appropriate care. Although Graduate Medical Education (GME) is funded by the federal government, government has little influence in directing how the money is spent. A recent IOM report concluded that GME's training goals should better align with those dictated by government. Some panelists thought the Center for Medicare and Medicaid (CMS) should oversee the funding, while others thought MEDPAC should oversee funding.

GME funding is paid to hospitals in two ways: Direct Medical Expenditure (DME) and Indirect Medical Expenditure (IME). DME funds pay for direct expenses like stipends and benefits for residents, while IME provides payments to teaching hospitals based on a complex calculation taking into consideration the ratio of patients to residents and accounting for the needier case mix of these institutions. Some panelists thought the current financing structure for GME is inadequate and should be expanded to support more residents and interns.

In response to the changing health care workforce needs of a growing Medicare population, the ACA created a new funding stream to direct money towards training a more informed Advanced Practicing Registered Nurse (APRN) workforce as well, called the Graduate Nursing Education fund (GNE). This is a pilot project that teamed up five hospital systems with colleges of nursing and appropriated \$200 Million over four years. This is the first time CMS funded clinical education beyond the physician level and recognized the new needs of the Medicare population.

### *J. Sanford Schwartz (Moderator)*

Stanford Schwartz is a clinically oriented health services researcher focusing on assessment of medical interventions, medical decision-making, and medical innovation adoption/diffusion. He suggested that projecting the needs of a medical workforce is “harder than hitting a baseball.” He cautioned “predictions are hazardous, especially when they are about the future.”

### *Gail Wilensky*

Gail Wilensky explained the recent Institute of Medicine (IOM) findings that evaluated the governance and financing of the GME with the goal of reshaping the financing structure to better help physicians meet the nation's needs. Acknowledging the difficulty of predicting physician residency and provider shortages, the IOM highlighted some important trends:

- Increasing the number of physicians in the country will not resolve important workforce issues, particularly without a focus on geographic distribution.
- The number of trained physicians in GME slots is not dependent on Medicare funds and only supports about 1/3rd of resident positions directly.
- There is an increasing specialized workforce being trained that lacks necessary teamwork and cultural competency skills.

Wilensky concurred with the report that GME financing is antiquated with no real link to the current needs of the residency system or outcome goals. Further, she said a heavy concentration of IME funding goes towards teaching hospitals in the Northeast. Moreover no one is able to truly track where the money goes once it hits the hospital door.

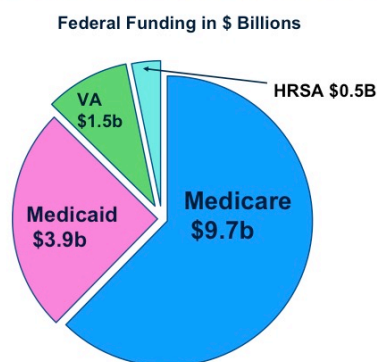
Wilensky highlighted four potential solutions to address the problems identified by the IOM report. First, maintain GME Medicare funding adjusted for inflation and reorganize training to adapt to today's needs. Funding should be gradually transformed to a performance-based system with greater tracking of expenditures and outcomes. Second, create a GME policy council in the Health and Human Services Office of the Secretary (HHS OS) to oversee a strategic plan for funding, sponsor physician workforce research, and create a better system of coordination between federal agencies and accreditation organizations. Concurrently a GME center within CMS should be created. Third, split Medicare funded GME into two subsidiaries including an operational fund to support current residency programs and a transformation fund to support innovative educational programs with the opportunity to grow from 10% of the budget to 30% of the budget. Finally modernize GME payments to be redistributed on geography based on the efficacy and value of the training.

### Susan Reinhard

Susan Reinhard focused on the ACA's Graduate Nurse Education (GNE) demonstration program which provides \$200 million over the years of 2012 to 2016 for five demonstration sites to train Advanced Practice Nurses (ARNPs) in community based settings. This program uses Medicare funds to train nurses that work largely with Medicare patients inside and outside the hospital. Training nurses for at-home or transitional care settings will better equip the workforce to deal with health care delivery system change. So far 13 schools and over 3,000 clinical training sites enrolled in the program. As a result ARPN enrollments and graduations have doubled. Further the diversity of nurses in training increased, as did the variation of clinical training sites. A mandated evaluation of the program's costs is due to Congress in the Fall of 2017, however many predict the implications of this program will remove barriers of practice for nurses and increase health care system efficiency.

### Linda Fishman

#### Illustration of the Magnitude and Sources of Federal GME Funding: 2011-2013 data



Source: Table 3-1, 2014 Institute of Medicine Report of Committee on Governance and Financing of Graduate Medical Education

Linda Fishman provided insight and reaction to the IOM Medicare GME funding recommendations outlined by Wilensky. Fishman examined the history of federal involvement in GME funding and the breakdown of funding (See Chart 1).

She explained how Medicare funds cover just a portion of graduate medical education, and although Medicaid is not required to contribute, about 42 states contribute some funding toward GME. She pointed to a very small Health Resources and Services Administration (HRSA) budget comparatively to support programs in primary care. HRSA training is specifically for medical

professionals working in "geographically isolated, economically or medically vulnerable" situations<sup>1</sup>. Of these limited funds, the Children's hospitals GME fund fell from \$318 million in FY2010 to \$265 million in FY 2014. This resource funds a small portion of the average 14 years of training often required of physicians and only marginally support community based training. What is needed is a fundamental restructuring of the way GME is funded.

She noted that current direct GME payments are based on a 1984 cost analysis and the 1997 Balanced Budget Act that caps the number of funded residents. This leaves academic medical centers responsible for some \$13 billion of direct training costs not paid through federal funds. The other source of federal support for graduate physician training, Indirect Medical Education (IME) payments were added to DRGs in 1983 based on the ratio of residents and interns to ratios of beds in each teaching hospital hospitals to residents, but payments have since then been cut in half. Also the number of residents funded by the federal government has been capped since 1997. Since then medical school enrollment has been outpacing resident slots with a 3% growth in medical school enrollment and only a 1% growth in residency spots. There is also no direct link between choice of specialty and funding. A range of incentives continue to push medical students towards specialization and away from primary care. Ultimately, Fishman believed the IOM report assumes hospitals control more of the GME than they actually do. She recommended that MEDPAC would be better suited to oversee GME.

<sup>1</sup> <http://bhpr.hrsa.gov/grants/teachinghealthcenters/>



## Discussion

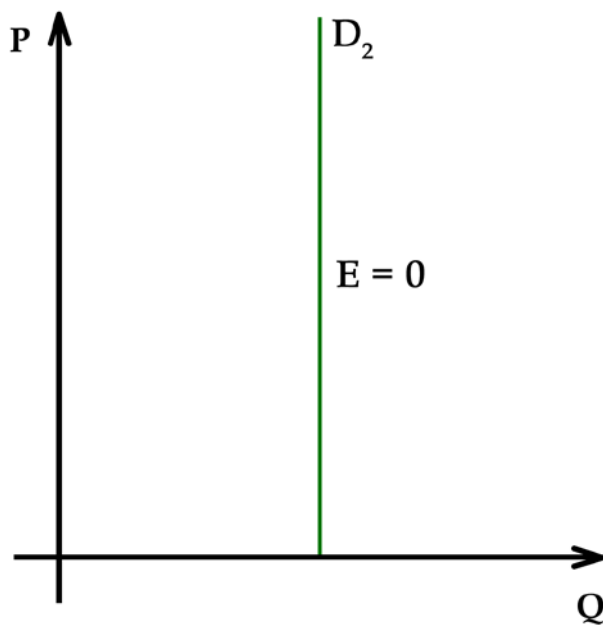
Julie Hutcheson Stoss of Kaiser Permanente suggested cutting back pre-residency training and adding more relevant systems of care training later in the process. Karen Feinstein said that the focus needs to change from simply how much we are paying for medical education to what we are paying for. We need to integrate more system based practice training and use data and technology to improve the quality of care. Gail Wilensky suggested creating selective loan forgiveness programs for students who choose primary care work. The session ended with a consensus that not only does the financing structure of medical education need to change, but it also needs to incorporate value-based incentives to drive better quality, cultural competency, and coordinated care.

## Session iii: Specialty Pharmaceuticals marketplace: is price inelasticity sustainable?

Pharmaceutical spending is rising rapidly and specialty drugs are a prime driver. Specialty drugs are predicted to account for 50% of total U.S. prescription drug spending by 2019 despite only holding 15-16% of the pharmaceutical market. Investors in the pharmaceutical market are dwindling and specialty drugs give the best yield on return. Additionally without price controls and statutory limits on the ability of public purchasers to negotiate price, insurers and public payers have limited ability to negotiate price and are forced to initially absorb the rising cost of drugs. These costs ultimately will be reflected in higher premiums. Panelists felt that the country will continue to pay what is charged, as there are few constraints on the quest for cures and treatments.

### Kevin Shulman (moderator)

Kevin Shulman defined specialty pharmaceuticals and outlined spending trends. Specialty drugs are tailored to treat conditions that generally affect a smaller subset of the overall population. From 2013 to 2014 spending on specialty drugs increased by 13.1%, which is equivalent to about \$371 billion dollars. Specialty drugs are expected to account for 50% of total pharmaceutical spending by 2019, despite them being only 15-16% of the pharmaceutical market. The promising outcomes that treat rare cancers or can even cure Hepatitis C lead them to be extremely inelastic in price, as

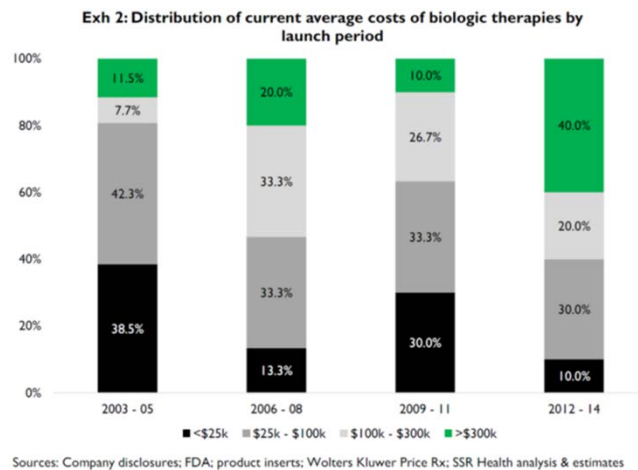


many would pay anything for a cure. The economic relationship of price and quantity with demand of specialty drugs can be seen in Graph 1, Inelasticity of Specialty Drugs. A vertical demand curve indicates a willingness to pay any price for any quantity of a potentially lifesaving drug. Despite the benefits of these drugs, the costs of inelastic pricing have broader financial consequences to the health care system and general government expenditures. For example for every 2.5% of the population on a \$100,000 drug, the total population's premium could go up \$250. This means that if 3-4 percent of the current population with Hepatitis C go on the new treatment this will have a significant impact on health care costs and be directly reflected in premiums.

### Justin Klein

From the investors' perspective, Justin Klein outlined why specialty drugs are more appealing investment than other types of pharmaceuticals. Venture capital firms respect both short-term and long-term business cycles, but are generally constrained in their funds to company investment time horizons of no more than 10-12 years and preferably 4-6 years. The testing and commercialization of most drugs take far longer than this window. Larger blockbuster drugs, for example, need to be tested on a wider population for side effects as well as efficacy. In contrast, specialty drugs can be tested more directly on a narrowly defined target population where benefits and risks can be more readily determined through smaller (and thus less expensive) clinical trials.

Although the ultimate market size for many specialty drugs can be comparatively smaller than blockbuster indications, the initial investment differences are materially smaller. With the attrition rate of failure in phase 3 studies oftentimes exceeding 50% for all pharmaceutical investments, venture capital is drawn more towards comparatively smaller investments in specialty drugs. At the same time fewer health care venture capital funds are being invested in "blockbuster" drugs. To make up for the smaller volumes associated with targeted specialty indications, investors will seek potential opportunities for developing and marketing specialty drugs where premium pricing is possible based on a drug's clinical and health economic value proposition.



### Richard Evans

With respect to prescription drug costs, Richard Evans reiterated the theme that, "in absence of links to quality or quantity, or failing these, the presence of external constraints, price runs free." He explained, "all else held constant, this inflationary process burns until it runs out of fuel." In our country we insist on the best technologies while dismissing substitutes and disregarding the sometime modest degree of new technologies' marginal advantage. What's more, despite high spending on specialty drugs in the pharmaceutical market, this category accounts for only 4% of total health spending – thus budgetary pressures aren't yet so large as to embolden policymakers to restrict patients' choices. Additionally although total out of pocket spending has increased dramatically, particularly for the top 1% of payers or specialty drug users, in general prescription drug spending remains relatively flat as a total of household spending (between 0.5-1.0% from 1965-2010). This is largely due to the fact that insurers and payers have absorbed the additional costs to shelter the consumers and most companies are offering co-pay cards that shield consumers from the higher co-pays associated with more expensive drugs. Sheltering consumers from the cost of pharmaceuticals will increase demand for the drugs and weaken political support for government price controls.

### Sean Tunis

More optimistically, Sean Tunis founder of the non-profit Center for Medical Technology Policy sees a road towards more value-based pricing. The pipeline of drug approval is so expensive, many stakeholders and society will want to ensure value at various levels. Value based pricing could incorporate prices that are proportional to incremental benefits. The range of benefits evaluated for pricing could include:

- Health benefits for the patient
  - Improved prognosis/survival, symptom/pain relief, improved functioning, etc.

- Other benefits for the patient
  - Financial, convenience, choice, etc.
- Benefits for families/caregivers
  - Financial, health, etc.
- Benefits for society
  - Improved productivity, public health, support for disadvantaged groups, etc.
- Benefits for health and social care system
  - Quality and cost, efficiency and care, etc.

Using this value framework with a patient centered outcomes focus; pharmaceutical companies can find a pricing benchmark that meets both the care value and the health systems value along with the opportunity costs of our country. Additionally we need to focus on what outcomes we are measuring and from whose perspective. For example, consider a drug for psoriasis. The producer was measuring how much the drug reduced the extent of the plaque affecting total surface area of the body, but what the people with psoriasis were most concerned about was the extent of plaque on their faces or joints. Ultimately, value and price should be increasingly determined by quality of evidence around impact on meaningful outcomes.

### *Julie Stoss*

From a Kaiser perspective in response to high pharmaceutical costs, Julie Stoss commented, “we can’t say no and we don’t want to.” Mirroring other panelists, she reiterated that we have very few cheaper alternative drug options, and even when we do come across one of those options, we will agree to pay for the more expensive ones. The pharmaceutical market is not a free market and payers have little ability to negotiate price. Drug companies have pushed for laws enacted in a number of states to restrict price negotiations on bio-similars, a market that is not even established yet. The focus should be on the value of drugs and the production cost allowing for a reasonable profit.

Government policy is not moving in this direction. The U.S. spends twice as much per capita on prescription drugs than most advanced countries. Medicare is also banned from negotiating drug prices. Additionally, the U.S. government subsidizes the development of orphan or specialty drugs through tax breaks on the front end, but does not require price concession on the back end. As a result over 1/3rd of orphan drugs make more than a billion dollars in sales and contribute to excessive profit margins. She concluded asking how much society is willing to pay for these drugs and advocating for a better balance between drug spending, patient and societal value.

### *Discussion*

Sean Tunis suggested that value based pricing and cost effectiveness analysis might be used to develop a more efficient pricing structure. This would take into consideration costs and benefits to patients and society. Sharon Levine of Kaiser suggested considering broader social costs of higher public spending on drug costs including reduced resources for investments in education and infrastructure. Anthony Barrueta, also from Kaiser suggested price should consider the total population being treated and adjust accordingly to be appropriate for the size of the demand; meaning price should have an economies of scale component. Ultimately, it was predicted that there are few barriers to continued cost increases.

## Session iv: The private insurance market: the influence of new payment and delivery models on changing provider practice patterns and consumer behavior

The private insurance market has the opportunity to use new payment and delivery models to reshape the health care delivery system. The importance of a value based benefit design was emphasized along with the idea of holding providers accountable for outcomes to entice real quality improvements and savings. The value of accountability from the insurers' perspective was similarly echoed and insight provided on how providers could mitigate risk of greater accountability by stratifying patients by risk. One challenge is the need for greater trust and collaboration between physician and insurers. Finally it was agreed and cautioned that models will need to vary by market and organizational structures, and there is no one size fits all pay for performance model.

### *Murray Ross*

Mr. Ross introduced the panelists and emphasized the importance of the private sector market moving towards a value based system.

### *Carmella Bocchino*

Carmella Bocchino explained that changes in payment and delivery models in the private market can be divided into four main themes: value based benefit design, transparency, innovative payment models, and collaborative provider partnerships. She indicated that the private markets span across all areas of health care with about 80% of ACOs within the commercial markets, 8% in Medicaid, and 6-8% in Medicare Advantage. With the new ACO framework, physicians and other clinicians are key players in case management, care transitions and population health. It is important for physicians to have actionable data with measureable outcomes to drive quality improvement and help ensure efficiency. Delivery reforms need to include accessible tools and infrastructure support to enable providers to make practice changes. Ultimately, they need to have more skin in the game. The Secretary has set ambitious goals for payment reform - transition to 50% alternative payment models and link 90% of fee-for-service payments to quality by 2018. Payment reform is and will continue to be a key factor to driving needed delivery reforms.

### *Stuart Levine*

Stuart Levine, Vice President of Blue Shield of California, explained how individual health insurance plans are part of a "three legged stool" with hospitals and medical groups for the delivery of care. If you take one leg out, the whole stool collapses. The private insurer should take responsibility in driving change in hospitals and physician groups through creating an environment of accountability, transparency, and having aligned incentives. To do this, providers need to reinvest where the patients are and stratify the risk of patients to ensure they are getting the right level of care. In Chart 1 below, Levine shows how his group devised 6 main pillars of care and risk to be stratified, and surmised if every patient is divided into one of these six levels, a waste of resources can be avoided.

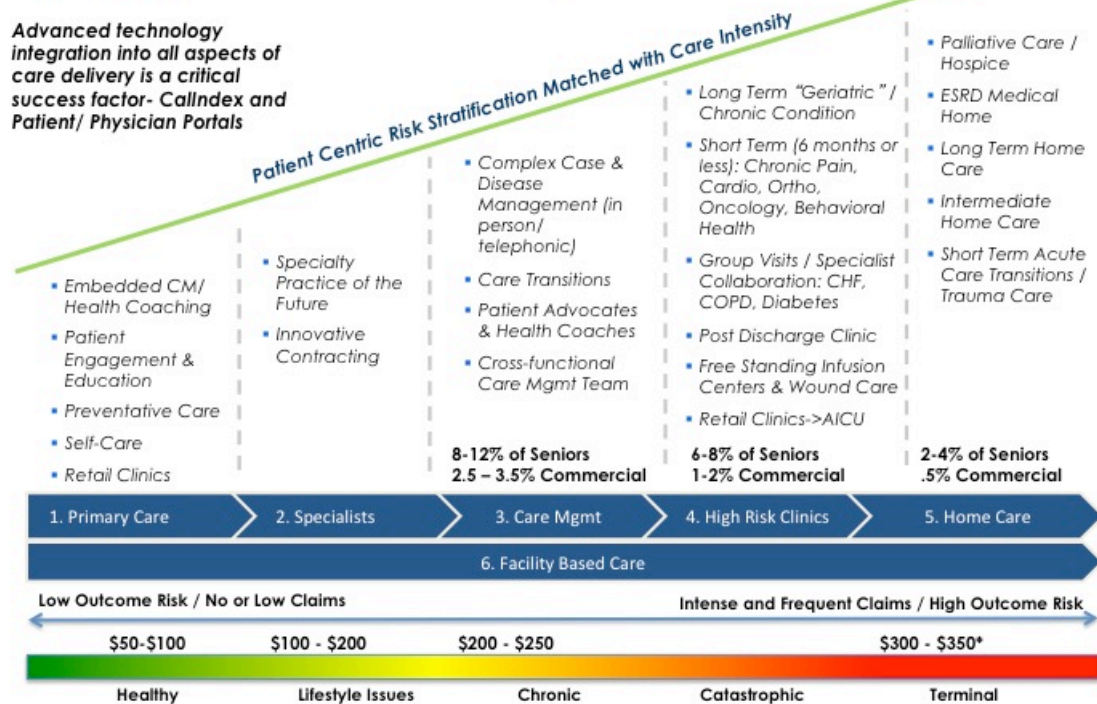
### **Chart 1: 6 Pillars of Risky Patients and How to Treat Them Appropriately**

**Source: Stuart Levine Powerpoint, Blue Shield of California**

Patients at each level of intervention should be engaged and empowered to their fullest ability as well as receive the requisite intensity of care. Additionally providers should be held accountable to measure outcomes, be rewarded for good performance and lose their patients for poor performance. However, even with the six-pillar delivery model, care will only change if insurers hold providers to a serious level of accountability.

## Applying 6 pillars of care based on patient stratification

Advanced technology integration into all aspects of care delivery is a critical success factor- CallIndex and Patient/ Physician Portals



\*Per Patient Treated Per Month; MMI cost is repurposed ~10-15% premium investment to achieve at least ~\$500M in hospital savings ~7-10: 1 ROI to reduce total Cost of Care

### Michael Chernew

Examining the bigger picture, Dr. Chernew noted that the bar for better quality is so low, that all the new quality incentivizing models look great. Fee-for-service (FFS) creates fragmentation in the delivery system, incentivizes quantity over quality, and makes it difficult to price reasonably or foster accountability. Pay for performance models (P4P) may improve quality, but still not address fundamental concerns. There is a huge range of alternative payment models including global models, episode bundles, and medical home based models. Evaluations of these programs have shown some improvements. The Alternative Quality Contract (AQC) model in MA showed significant savings from 2009 to 2012 with an average of 7.63% savings over the four years due to the ability to shop for physician organizations and exploit price variation.<sup>2</sup> Pioneer Accountable Care Organizations (ACO) on average showed about a 1.2% savings, with greater savings found in the more expensive ACOs. ACO's quality improved the most for sicker patients, while it remained the same or slightly better for the rest of the population. Some nearby organizations to the ACOs who did not participate did better as well, acting as "free riders" to the improvements of the local patient population. There is still an enormous amount of experimentation, but the FFS system is untenable and we will need to continue to shape the delivery system to maintain high levels of accountability for all organizations and help providers achieve greater efficiency.

### Discussion

Audience members voiced a need for improved data exchange and virtual integration to create an infrastructure to support the shift from fee-for-service to pay-for-performance. Jay Crossen from MEDPAC asked if CMS has taken a

<sup>2</sup> (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4261926/>)

serious look at the ACOs who dropped out and organizations that have not yet participated in order to address concerns for the next generation of ACOs. Ultimately, the consensus was that the private insurance market needs to not only hold providers more accountable, but give them more access to data tools and analytical supports in order to truly influence better quality and less spending in the health care market.

## Session v: Major issues affecting Medicare going forward

All panelists who were present were supportive of Medicare and suggested that it is on the right track testing important payment and quality initiatives. One of the invited speakers Jim Capretta was unable to make it because of a train accident in the Northeast corridor. It was expected that Capretta would have been more critical of the current state of the Medicare program. The panel supported the ACA Medicare expansions and the coverage the program provides. Areas for improvement included the consolidation of the fragmented structure of the Medicare program to better coordinate care, recoup administrative costs and demystify the complex enrollment process for beneficiaries. The move from volume-based toward value-based payment promises to improve the efficiency and effectiveness of the program. To help cover the gaps for low to moderate-income beneficiaries, a sliding scale for Part B premiums and perhaps other out-of-pocket costs could be established. Private plans could play a central role in helping to streamline the traditional Medicare structure. The program may need to be modified to provide better coordination for the 10,000 new baby boomer beneficiaries enrolling in the program each day.

### *Stuart Guterman (Moderator)*

Medicare covers a large and growing population with extensive health care needs. It accounts for a significant percentage of the federal budget and national health care spending, and serves as platform for developing innovative payment and delivery system models. Since its inception, the Medicare program has continued to evolve, increasing eligibility in 1972 and adding drug coverage in 2006, coupled with significant payment reform and quality initiatives from the mid-1980's to the creation of ACOs in 2012. The ACA extended coverage to preventative services without cost-sharing, phased out the "doughnut-hole" in drug coverage, and encouraged payment and delivery system reforms through the Center for Medicare and Medicaid Innovation, including bundled payments and multi-payer initiatives. With many positive reforms coming from Medicare, Guterman cautioned there are still many challenges in the program.

In particular, he highlighted rising expenditures in part due to the increasing number of beneficiaries along with the incidence of multiple chronic conditions. Medicare continues to be fragmented into its components: Parts A & B or C, D, and Medigap coverage. Coverage gaps still remain for long term care. With no limit on out-of-pocket costs, sick and poor beneficiaries are particularly vulnerable. With the role of private plans rising, there may be opportunity to leverage the traditional Medicare and Medicare Advantage programs to address some of those challenges. Ultimately, Guterman and fellow panelists were optimistic about what Medicare could achieve with properly-targeted reforms.

### *Jonathan Blum*

The ACA dramatically lowered the projected program spending of Medicare. Jonathan Blum suggested that the main driver in current spending growth is the aging population and increased Medicare eligibility. Despite lowering reimbursements to private Medicare-Advantage plans post ACA, more people are enrolling in these private plans over traditional Medicare plans than anticipated. One estimate is that the proportion of Medicare Advantage enrollees could increase from the current 29% to as high as 45% by 2020. Medicare Advantage already dominates some metropolitan markets, such as Miami-Dade Co. with 62% enrolled in these private plans.

Medicare changes in the ACA have increased access to preventive and primary care with a significant increase in care management. Better care coordination holds the possibility of lower medical costs. However, the largest increases in

Medicare costs are in Part D, with the introduction of new, expensive drugs (8.5% of expenditures), and Part B, with the availability of new, expensive technologies (6.9% of expenditures). Old Medicare evaluation standards based on national cost trends, solvency, administrative cost and providing similar benefits to all beneficiaries needs to be reconsidered. New innovation needs to focus on geographic differences, lowering drug costs, serving patients with multiple chronic illnesses and providing coordinated care.

**Traditional Evaluations of Medicare Proposals Included:**

- Will it reduce costs over a 10-year period?
- Will it slow the growth of overall trend?
- Will it improved Medicare solvency?
- Is it equitable in terms of costs to all groups?
- Is it fair in terms of similar benefits to all beneficiaries?
- Would administrative costs change?

**New Evaluations of Medicare Proposals Should Include:**

- Will it have the greatest impact in different geographical locations?
- Can it lower pharmaceutical spending without restricting access?
- Does it serve patients with multiple chronic conditions?
- Will it drive better payment and case management policies for providers?
- Does it drive optimal organization of delivery?

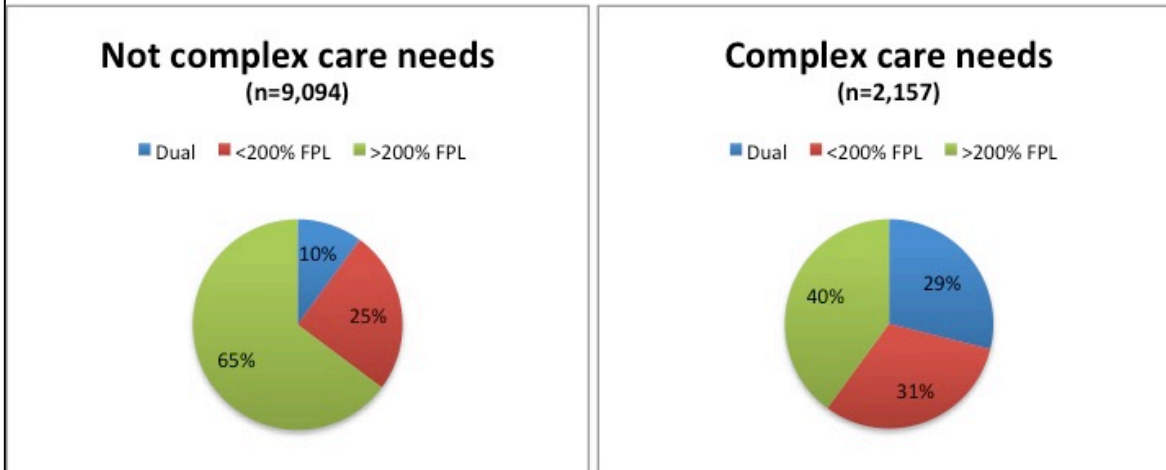
*Karen Davis*

Karen Davis noted that this year Medicare had the lowest rate of increase in spending ever. Medicare is also an innovator in payment and delivery system reforms. Despite success, she identified future challenges to include the retirement of the baby boomer generation. On an aggregate basis this will cause spending to outpace GDP growth, despite spending per beneficiary growing more slowly.

Another significant problem is the financial burdens on low to modest-income beneficiaries including the cost of premiums, cost-sharing and uncovered services. This is a particular problem for beneficiaries with multiple and complex needs. The chart below shows an increasing number of dual eligibles and those at or below 200% of the FPL with complex needs. Here Davis defined those with complex needs as those with two or more impaired activities of daily living (ADLs). Without appropriate home care and coordination many of these patients are placed in nursing homes. The right-hand pie chart below shows that the most complex Medicare patients have the smallest amount of financial resources. These beneficiaries can be required to pay more than 20% of their income to cover their out of pocket health care costs, burdening the beneficiary and their families. To resolve this growing inequality and impending spending growth, we need to redesign care delivery of the Medicare program to include one single comprehensive benefit package with a sliding scale that refocuses on the physical and cognitive limitations of aging. Medicare should also incentivize providers to keep beneficiaries at home when appropriate. It should no longer remain standard practice to wait for people to exhaust all their assets until they end up on Medicaid.

## Distribution across income categories among complex care needs beneficiaries compared to among non-complex care need beneficiaries

9



Source: Analysis of the 2010 Health and Retirement Study data; Roger C. Lipitz Center, Johns Hopkins School of Public Health



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### Discussion

Jonathan Blum who is now with CareFirst Blue Cross Blue Shield suggested that the Centers for Medicare and Medicaid Services (CMS) needs to look at data by local area to develop more localized benchmarks for payment and other policies. He used South Florida as an example of where both the quality and efficiency of care are poor. He also suggested that improved risk adjustment could counteract the incentive for providers and plans to “cherry pick” less expensive patients and enrollees. Karen Davis highlighted the importance of CMS investigating the needs of new beneficiaries and perhaps redefining care teams to include lower cost health personnel to help with case management.

### Dinner Night Two: Using Stories to Describe Important Issues

Lee Gutkind, the founder and editor of Creative Non-Fiction magazine shared how he transformed a three-year national science foundation grant into a publication that brings technical knowledge and issues to life in an approachable style. In such a complicated world, Mr. Gutkind stressed the importance of using stories to communicate important messages to a broad reader base. This is particularly important in health policy where it is hard to grasp the details of important topics like consumer directed health plans. By helping the public understand and connect to health policy issues through stories, people will be more informed and empowered.

The human fascination and obsession with stories is evidence based as research has showed people remember more facts for longer periods of time when presented through the frame of a story. Using the lens of the Law & Order



television series, Gutkind showed that the most compelling stories do not start out by telling exactly what is going to happen, but rather lead in with what is at stake to draw the reader in. Then like the Law & Order series, the reader remains enchanted by the ups and downs of a descriptive scene, more information, scene, information, etc. and so forth until the conclusion. He argued that if authors could twist any topic into this framework, readers would leave more informed and interested in the material than if it was written in a white paper format.

Alan Weil, former contributor to Creative Non-fiction and current editor of Health Affairs reiterated the importance of narrative in any type of published work. He provided an example from his past work where researchers were noticing extreme problems in workforce diversity of race and gender long before they had quantitative data. They compiled narrative data to tell a significant and important story that led to more quantitative research and ultimately policy changes. While policy decisions should not be based solely on anecdotes, it can be powerful to combine data and analysis with narrative.

## Session vi: Report from CMS office of the actuary: Update on the latest trends in health care spending

### *Stuart Altman*

Stuart Altman substituting for Stephen Heffler, Director of National Health Statistics in the Office of Actuary at Center for Medicare and Medicaid Services covered the latest spending trends using preliminary data from the Center for Medicare and Medicaid Services.

Overall spending was relatively flat for 2014 and began to tick up in 2015. Similarly, although utilization began to creep up as the economy improves; it has also been largely moderate to flat. It has become conventional to say that the key to reducing costs is to simply cut back on useless care. This turns out to be anything but simple. The public doesn't like this. For them, good health care is what their doctor tells them they need. Efforts to change this relationship undermined managed care in the 1990s. Altman suggested that the real historical driver of costs is price growth.

If it is price that drives spending, it will still be difficult to control, because it entails taking away someone's revenue. We are all guilty of benefiting from this inefficient inflationary system. In Europe, for example, there are fewer health care consultants and they don't dress as well as we do. Doctors and nurses don't make nearly the income they do in the U.S. On the use side while we do use more expensive tests and procedures than OECD countries, we actually use less hospital care, visit the doctor less often and use less drugs. s less than OECD nations. The big difference in spending between the U.S. and with Europe is the priced charged for the services used.

What are the trends? Prices and utilization are beginning to once again trend up driven by drugs and hospital cost. Prices are moving from flat to moderate growth while utilization is expanding due to an aging population and improvements in the economy. People are thinking again about getting new knees and hips, which might have been delayed during the recession. Drug prices are high. And there continues to be huge variation in price and spending across the market.

ACA expansion will have an impact on spending cost. The Medicaid expansion will include a onetime bump as people with delayed needs access regular care, but immediate high usage will calm down. All the increases in Medicaid spending can be attributed to utilization. New Medicare enrollees are coming in healthier and may actually reduce average costs.

## *Discussion*

Concern was expressed that providers manipulate where care is delivered in order to increase charges. For example shifting care from a physician's office to a hospital setting can yield triple the reimbursement. There are also huge price premiums for drugs delivered in the hospital. For example, cardiologists are switching from private to hospital based because of increased reimbursement.

Some suggested that costs have been stable because of higher cost sharing. But that this is catching up with us. Employer based insurance is increasingly moving to high deductible plans. On the drug front, companies are trying to increase revenues as older drugs come off patent. Investors need higher returns to take money away from safer less risky options.

## **Session vii: Quality- has the health care system made sufficient progress?**

This session evaluated the progress of health care quality efforts over the past 15 years including efforts to prevent costly episodes of care, remove waste, lower costs, and improve outcomes. Major themes emerging from this discussion found that overutilization and medical errors are still a hindrance to quality improvement, structural changes for integration must be made at every level of care, and hospital administrators need to have greater accountability for their hospital's outcomes.

### ***Karen Feinstein (Moderator)***

Karen Feinstein emphasized the need for sustainable structural change on a large scale. She described the situation as; "You can't plant a turnip in cement," meaning a seed will not grow in cement or a few technical quality changes will not have a system wide effect without organizational change. Below is Feinstein's graphic highlighting the different changes or "layers of dirt" needed for a true systematic quality improvement or "turnip" to grow in our current clinical environments. In this contextual framework, the very foundation is incentives for high performance and layers work their way up to leadership with vision. Starting from the bottom, Feinstein emphasized that success requires coordination and commitment throughout organizations, similar to the "zero deficiency" theory in other high quality industries. Without system-wide changes, lasting quality improvement is unachievable.

### ***Gordon Mosser***

While progress has been made, we have a long way to go to reduce significant waste and limit medical errors. Gordon Mosser said that in Minnesota alone, providers consistently performed 15 to 20 wrong procedures a year since 2008. Further, we continue to see extreme overuse of unnecessary services and procedures. Mosser also blamed slowed movement in quality improvement on the lack of adequate leadership and management. He suggested that current organizational structures simply impede process improvements. For example, nurses are continually moving around, doctors are becoming ever more specialized, and these moves are coupled with poor collaboration and little training in teamwork. In today's current environment Mosser described physician's collaboration as simply a "courtesy" and "duck tape" over what could be real integration and quality improvement. He emphasized the need for adaptive teamwork training in medical school beyond the subset of 10% of schools currently offering this training. Ultimately he stressed, "team stability improves safety."

### ***Neel Shah***

Neel Shah suggested that quality varies significantly between hospitals and is contingent on "which door one walks through." He used the example of Caesarean Sections (C-Sections) to make his point. For starters, it is estimated that about half of these surgeries performed in the U.S. are unnecessary. This equates to about \$5 Billion in unnecessary costs for the surgeries and the additional complications of hemorrhage, infection and organ injury that could have been

avoided with natural births. Shah postulated a possible correlation and/or causation with this trend and the rising maternal mortality in the U.S. for the past 20 years. Further there is a ten-fold variation between hospitals in C-section practices. In fact the most predictive factor of receiving a C-section is the hospital. This explains far more than the preferences of patients or doctors and is just an example of one procedure.

### ***Michael Millenson***

Michael Millenson highlighted persistent quality problems such as inadequate transparency, unnecessary care, failure to administer evidence-based medicine, the lack of health information technology, limited value based purchasing, and ongoing medical errors. He attributed slow change to the theory of “duty vs. interest,” alluding to the difference between a hospital’s duty to perform well versus an interest in improving quality. He cited a 2014 study by Wilson et al. in the American Journal of Infectious Control which indicated significant savings for infection prevention strategies of children with Leukemia (around \$70,000 per child) yet no new hospitals implemented these controls. Most likely reason for this lack of change was because “change” was not in their interest. Part of this problem can be attributed to the lack of accountability by hospital executives and administrators for quality improvement. He also said it will be essential to pay hospitals in a public and transparent fashion based on quality measures to incentivize change as a “duty” rather than an “interest.”

### ***Discussion***

One attendee pointed out that success requires understanding the downstream effect of policies on physician practices and hospitals. Changing one little NOCA standard could require changing multiple and varied reporting requirements with the unintended consequence of rendering the data meaningless. We need to streamline the reporting and stick closer to a uniform set of measurements. Another attendee suggested that the workforce panel could have focused additional attention on teamwork. He also suggested that NIH and other funds invest in implementing evidence based best practices rather than new discoveries and technologies. It was also argued for fast change to happen, CEO salaries and bonuses need to be tied to meeting high quality standards.

## **Session viii: The political scene**

This panel discussed the political, legislative, and legal factors that led to health care reform, efforts at repeal, and the recently passed Medicare Sustainable Growth Rate (SGR) bill. Some discussion also revolved around King v. Burwell decision, which was subsequently resolved in favor of maintaining current ACA subsidies.

### ***Chip Kahn (Moderator)***

Chip Kahn suggested that the deep ideological and philosophical political divide between the political parties on the ACA and Medicaid should be taken seriously. These are strongly rooted views on the proper role of government. Certain states are not expanding Medicaid because they don’t believe it is the right policy. Kahn suggested that the passage of the SGR bill does not represent the first of many compromised between the deeply divided parties. It came together because of many unique factors, including a fair number of doctors in the House. Similar compromise for example if the King v. Burwell ruled against the ACA would be hard to imagine with gridlock a more likely scenario.

### ***Jay Kholsa***

Jay Kholsa, Senior Republican Senate Finance Committee Policy Director outlined the factors he believed were necessary for the compromise that led to the SGR bill. He suggested that the SGR fix passed because of three main components: crisis, opportunity, and grind. He described how over the last decade Congress passed temporary fixes to stop draconian provider payment cuts pushing the crisis forward for another year. He also said that years of fixes led to

“grinding” pressure on all parties for a permanent fix. Funding was a critical issue and once the parties agree not to talk about offsets, the bill had a much easier path to passage. Kholsa also suggested that Congress might begin to take a different path with the ACA. Specifically there might be more targeted approaches instead of wholesale repeal. This has been a difficult track because it could have been seen “fixing.”

### ***Amy Hall***

Amy Hall, Senior Democratic Staff on the Ways and Means Committee, agreed with much of Kholsa’s analysis of the SGR fix. She added that it was essential to have a combination of leadership and direction from the top coupled with the details, knowledge and expertise from the below. Amy hoped that a decision in *King v. Barwell* supporting the ACA subsidies would reduce divisiveness and help Congress “get back to business.” This may set the stage for increased compromise over the rest of the session. There was some hope for potential compromise on Health Information Technology and Interoperability but this would still require a greater willingness for compromise that will still be a challenge.

### ***Bill Gradison***

Bill Gradison, Commissioner Medicare Patient Advisory Committee thinking was in line with Chip Kahn’s notion that the SGR fix will not break party gridlock. He expects the SGR fix will be the only significant Medicare action this year. He recounted that the SGR was a problem for over a decade. The real challenge was what to replace it with and more important how to pay for it. The compromise was not to pay, but to increase the debt. He advocated more efforts to tie reimbursement to quality outcomes, but suggested that moving in this direction requires better risk adjustment methods. Generally, paying for quality is really hard and complicated by the diversity of providers, care settings, and variation in health care delivery system throughout the country.

### ***Stuart Butler***

Stuart Butler, Senior Fellow Brookings Institute, suggested that a Supreme Court decision against ACA subsidies could be the crisis that spurs innovation and bipartisanship. Butler stated that Republicans, although they are philosophically opposed to the ACA, are still concerned about reduced resources and subsidies in their state. Potential political opposition from the right holds back Republicans from trying to fix some of the problems with the ACA. They do not want to be seen as supportive of “Obamacare.”

Butler suggests that the use of state innovation could be an avenue for progress and be used to bridge the considerable differences between the parties. Section 1332 of the ACA allows the states to make major modifications to the ACA. Here states could significantly test new models from the right and the left. The challenge is that this provision does not take effect until 2017. Pushing up this provision holds a lot of promise to address many of the concerns with the ACA. Republicans could support without directly embracing the ACA and in fact enable alternatives. Democrats could also find advantage by broadening support and maintaining the program in states in which it is working.

### ***Conclusion***

The conference covered the most pressing issues in American health care and examined potential strategies to increase health care system efficiency. The health care system is in a state of flux driven by the implementation of the ACA coupled with a divided government. This new environment impacts the health care delivery system, public and private insurance programs, health plans, hospitals, providers, the pharmaceutical industry, medical device manufactures in addition to consumers and patients. Some shifts may replicate past movements towards managed care, but with increased engagement of providers, there is hope for better integration, improved quality, and price stabilization. Mergers may do as much to protect market share as drive efficiency. New payment models and quality initiatives show some promise but there are still many questions and issues with scale. Costs are also beginning to creep up again. There is also considerable variation in change and outcomes between states and regions. The conference was a snapshot of large change in transition, but the final outcomes and impact is yet to unfold and will be the subject of continued investigation. Ultimately many remained hopeful that we could continue to strive towards better care