

**Council on
Health Care
Economics and Policy**

Where Do We Go From Here? The Future of Health Reform

The 18th Princeton Conference

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The 18th Annual Princeton Conference focused on the future of health care reform and the many implications of the landmark Affordable Care Act (ACA).

Passage of the Affordable Care Act represented an enormous milestone for the country. It broadens coverage, expands Medicaid, creates insurance exchanges, brings about accountable care organizations, and seeks to drive innovation, payment system changes, and delivery reform.

Panelists looked at historical political lessons that helped the Obama administration get this legislation passed, as well as the President's role in leading ACA's passage. Those who opposed this legislation and want it repealed weighed in and shared their perspectives.

Several panels looked at the implementation of aspects of the ACA, with an examination of insurance regulations, state health exchanges, Medicaid expansion, ACOs, the Innovation Center, and much more.

Looking beyond implementation, panels discussed the impact of the ACA on health care spending and examined strategies to constrain the unsustainable growth of health care costs. Panels also looked at how health reform will affect the quality of health care that is delivered and how quality should be measured. Panels also discussed payment reform and how the delivery system needs to change to deliver more coordinated care.

This policy brief presents the major findings from each session at the 2011 Princeton Conference.

Table of Contents

Session	Speakers	Page
Session I Health Reform: A Look Back and Lessons Learned	Moderator: Stuart Altman, PhD <i>Sol C. Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University</i> Presenters: Michael Hash <i>Director, Office of Health Reform, Department of Health and Human Services</i> Chris Jennings <i>Former Senior Health Care Advisor to President Bill Clinton; President, Jennings Policy Strategies, Inc.</i> Robert Reischauer, PhD <i>President, Urban Institute</i>	6
Session II The Changing Private Insurance Market and the Role of States in Implementing Reform: New Federal Regulations	Moderator: Mary Ella Payne <i>VP, System Legislative Leadership, Ascension Health</i> Presenters: Sherry Glied, PhD <i>Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services</i> Dan Durham, MPP <i>Executive VP, Policy and Regulatory Affairs, America's Health Insurance Plans</i> Len Nichols, PhD <i>Director, Center for Health Policy Research and Ethics; Professor of Health Policy, College of Health and Human Services, George Mason University</i> Stuart Butler, PhD <i>Distinguished Fellow and Director, Center for Policy Innovation, The Heritage Foundation</i>	9
Session III State Health Exchanges	Moderator: Jon Kingsdale, PhD <i>Managing Director, Wakely Consulting Group</i> Presenters: Anne Gauthier, MS <i>Senior Program Director, National Academy for State Health Policy</i> Timothy Jost, JD <i>Robert Willett Family Professor, Washington and Lee University</i> Bruce Greenstein, MS <i>Secretary, Louisiana Department of Health and Hospitals</i> Sandra Shewry, MPH, MSW <i>President and CEO, CA Center for Connected Health</i> Alissa Fox <i>Senior VP, Office of Policy and Representation, BlueCross BlueShield Association</i>	13
Session IV Should We Put the Brakes on Health Reform: Impending Challenges and Alternative Designs	Moderator: Charles N. Kahn III, MPH <i>President and CEO, Federation of American Hospitals</i> Presenters: James Capretta, MA <i>Fellow, Ethics and Public Policy Center</i> Tom Miller, JD	17

Session	Speakers	Page
	<p><i>Resident Fellow, American Enterprise Institute</i> John McDonough, DrPH, MPA <i>Professor of Public Health Practice, Harvard School of Public Health; Director, HSPH Center for Public Health Leadership</i> Ron Pollack, JD <i>Executive Director and VP, Families USA</i></p>	
Session V Future Health Care Spending: Political Preferences and Fiscal Realities	<p>Moderator: Uwe Reinhardt, PhD <i>James Madison Professor of Political Economy and Professor of Economics, Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University</i></p> <p>Presenters: Paul Ginsburg, PhD <i>President, Center for Studying Health System Change</i> Stuart Guterman, MA <i>VP, Payment & System Reform, The Commonwealth Fund</i> G. William Hoagland <i>VP of Public Policy, CIGNA</i> Henry J. Aaron, PhD <i>Senior Fellow, Economic Studies, The Bruce and Virginia MacLaury Chair, Brookings Institute</i></p>	20
Session VI The President, the Public, and Health Reform	<p>Moderator: Susan Dentzer <i>Editor-in-Chief, Health Affairs</i></p> <p>Presenters: Robert Blendon, PhD <i>Senior Associate Dean for Policy Translation and Leadership Development; Professor of Health Policy and Political Analysis, Department of Health Policy and Management, Harvard School of Public Health</i> David Blumenthal, MD, MPP <i>National Coordinator, Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services</i></p>	23
Session VII Health Reform and Medicare: What Does it Mean for a Restructured Delivery System?	<p>Moderator: Darrell Kirch, MD <i>President and CEO, Association of American Medical Colleges</i></p> <p>Presenters: Robert Berenson, MD <i>Senior Fellow, Urban Institute</i> Jay Crosson, MD <i>Director of Public Policy, The Permanente Medical Group; Senior Fellow, The Kaiser Permanente Institute for Health Policy</i> Gary S. Kaplan, MD, FACP, FACMPE, FACPE <i>Chairman and CEO, Virginia Mason Health System</i></p>	26

Session	Speakers	Page
Session VIII How Will Health Reform Improve Quality and Increase Access?	Moderator: Karen Wolk Feinstein, PhD <i>President and CEO, The Jewish Healthcare Foundation and Pittsburgh Regional Health Initiative</i> Presenters: Donald Berwick, MD, MPP <i>Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services</i> Christopher Tompkins, PhD <i>Director, Institute on Healthcare Systems; Associate Professor, The Heller School for Social Policy and Management, Brandeis University</i> Ziad Haydar, MD <i>VP, Clinical Excellence-Physician Integration, Ascension Health</i> Elliott S. Fisher, MD, MPH <i>Director, Center for Population Health, The Dartmouth Institute for Health Policy and Clinical Practice</i>	30

Session I: Health Reform: A Look Back and Lessons Learned

- Moderator: **Stuart Altman, PhD**, *Sol C. Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University*
- Presenters: **Michael Hash**, *Director, Office of Health Reform, Department of Health and Human Services*
Chris Jennings, *Former Senior Health Care Advisor to President Bill Clinton; President, Jennings Policy Strategies, Inc.*
Robert Reischauer, PhD, *President, Urban Institute*

Overview

Lessons learned from the unsuccessful attempt by the Clinton administration to reform health care helped President Obama and Democratic leaders win passage of the Affordable Care Act. These lessons include tackling health care early in the presidency, making it the top priority, allowing Congress to craft the legislation's specific details (with general guidance from the President and his team), understanding how the CBO will score proposed legislation, and securing broad stakeholder support.

While conference attendees don't believe the legislation would have passed with stronger cost controls, and while panelists argued that the cost controls in ACA are significant, not all participants are convinced that ACA does enough to control costs.

Context

These panelists shared their observations on the passage of the Affordable Care Act (ACA), describing how its passage drew from lessons learned from past failed efforts to reform health care.

Key Takeaways

- **The approach of the Obama administration worked in getting ACA passed.**

Passage of health reform was no overnight sensation. Chris Jennings said ACA's passage was the culmination of decades of activity, going back to President Truman, and including efforts in the Nixon, Carter, and particularly the Clinton administrations. Even with all of the prior efforts focused on broadening coverage and reforming health care, Robert Reischauer didn't see the passage of ACA as inevitable. All of the panelists believe many factors conspired to bring about its passage.

Michael Hash, who directs the Office of Health Reform at the Department of Health and Human Services, provided the perspective of the Obama administration. Going back to the presidential campaign, President Obama's general approach was to prioritize health care reform that

focused on coverage, quality, and cost. From the beginning the Administration focused on:

- *Making a case for health care reform.* The 160 million people who already had health insurance had to understand how health care reform would benefit them. They had to understand that the health insurance market would function more effectively and efficiently for them.
- *Fundamentally changing the health care delivery system.* The Administration recognized that both the financing and organization of care had to change. The country must move away from the current payment system that rewards providers for delivering more care and from the fragmented delivery system. The delivery system must provide better quality and patient safety.

"There was a recognition from the beginning that the health care delivery system, both in the financing and the organization of care, had to be fundamentally reformed."

— Michael Hash



- *Controlling costs.* Per Mr. Hash, "The cost issue was equally if not more important than the other two [insurance reform and delivery reform]." As a result, health care reform legislation contained in some way virtually every possible idea to improve efficiency and cost effectiveness.

The approach of the Administration (discussed in more detail below) was not to put forward its own proposal, but to work with Congress on the specific legislation, ensuring that this legislation address the building blocks outlined above. The passage of this legislation shows that the approach worked.

- **Instrumental in the passage of ACA were the people, policy, process, and environment.**

Mr. Jennings felt strongly that ACA would not have passed if not for the lessons learned from previous attempts to reform health care, particularly the effort by the Clinton administration (which he was a part of) to pass the Health Security Act in 1993.



"In my mind, without the Health Security Act we probably wouldn't have had the Affordable Care Act, in many ways, mostly because we made so many mistakes that you could learn and apply."

— Chris Jennings

Mr. Jennings analyzed the passage of ACA by looking at the:

— *People*: Mr. Jennings believes President Obama showed strong leadership at key junctures. In the fall of 2009 and after Scott Brown won Ted Kennedy's Senate seat, many people advised the President to take an incremental approach, but he rejected this advice, made health care his top domestic priority, and spent political capital. (Mr. Reischauer believes Senator Brown's election gave Democrats a sense of urgency to act.)

The leaders of Congress, committee chairs, and members of Congress also deserve credit. There were no jurisdictional squabbles and there was support from all committees. Also critical was the support, or at least the lack of active opposition, from all key stakeholders, who saw health care reform as better than nothing.

Lastly, many of the people involved in ACA were veterans from the 1993-94 debate. Their experience helped in getting ACA passed, and many were motivated, seeing this as perhaps their last opportunity to get health care reform passed.

— *Policy*: Many key parts of the final policy in ACA were very different from 1993. ACA has no mandatory alliance, no premium caps, and no employer mandate. And, despite posturing by the Republicans, the ideas in ACA are very bipartisan. The ideas of a private insurance market, a state-oriented approach, and an individual requirement are not Democratic ideas.

In 2010 versus 1993, there were fewer policy differences among the Democrats. This time around, Democrats had an attitude of wanting to get something done.

— *Process*: A painful lesson from 1993 was development by the White House of a detailed bill for Congress to critique. With ACA, Congress developed the detailed bill, which was a critical difference. Because the committees developed the policy, committee members were more invested and supportive. Part of the process of gathering support within committees entailed getting input from and cutting deals with a wide range of stakeholders. As a result, no major stakeholders opposed this legislation. This included the AMA, AARP, pharma, hospitals, labor, and big business. The major insurers were portrayed as the bad guys, but even they didn't oppose ACA, as the individual mandate results in new customers.

Another key part of the process, which may have been unintentional, was using the public option as a foil. This topic dominated the debate. When conservative Democrats got this taken off the table, they pledged their support. Had this not been such a foil, this group likely would have demanded other concessions. The process worked quite well.

— *Environment*: The earlier passage of the Medicare drug benefit removed a major barrier that made it possible to get to the next big health care debate. If the drug benefit weren't already in place, it would have been hard to expand coverage.

Mr. Jennings also believes that luck and serendipity played a role. He pointed to a significant premium increase by WellPoint, showing the need for cost control, at the height of the debate.

■ **ACA had both similarities and significant differences compared to the Health Security Act of 1993.**

Mr. Reischauer identified several factors that were the same in 2010 and 1993, along with several key differences.

Similarities

- A new president with an ambitious agenda.
- A terrible economy.
- Extreme budgetary pressures causing a focus on costs.
- An attitude that legislation should be paid for. (This was more acute in 2010 because Congress felt remorse for the prescription drug legislation, which wasn't paid for.)
- Big campaign promises, which led Democratic activists to have high expectations.

Differences

- The economy in 2009 was even worse than in 1993. As a result, more people were concerned about the rising number of uninsured. People in the middle class saw those without insurance and said, "This could happen to me."
- The political environment was more politicized in 2010, fueled by a different media environment.
- There were no true leaders in the Congress on this issue, in contrast to the past.
- The involvement of the Congressional Budget Office (CBO) was different. The CBO was out in front with information about how different aspects of legislation would be scored, and the Administration paid attention to the CBO.
- Many of the concepts were now familiar, including ideas like risk adjustment and exchanges. Also, a key difference that increased familiarity was the existence of a real-life example in Massachusetts.
- The President's wife wasn't leading health care reform.

Mr. Reischauer agreed with Mr. Jennings that perhaps the key difference was that the White House didn't dominate the policy formulation process. They learned from the failed Clinton approach to reform health care and from the success of the Bush Administration on several policies to let Congress hammer out the policy details.



"What lessons did this administration learn [from 1993]? Don't have the White House dominate policy formulation."

— Robert Reischauer

- **The panelists didn't believe that health care reform legislation could have been passed any faster.**

Stuart Altman raised the question why it took so long for health care reform to be passed, and asked whether it could have been passed sooner.

The panelists were of the view that it could not have been done sooner. There was previously inadequate political support, which Mr. Reischauer attributes to general ambivalence about health care insurance among those who have political power (who are themselves well insured). The Medicare drug benefit hadn't yet been passed, and the stakeholders weren't ready to make concessions. Thus, it wasn't possible to pass this legislation any sooner than 2010.

- **Since ACA was enacted, the Administration has focused on implementing reforms in the insurance marketplace and in the delivery system.**

Mr. Hash explained that since ACA has been enacted, the priorities of the Administration have been:

— *Implementing reforms in the insurance marketplace.* This has been the leading priority. In particular, the Administration has focused on the two most dysfunctional markets: the individual and the small group markets. The schedule was ambitious, with some reforms effective December 23, 2010, just seven months after ACA was signed.

— *Putting in place delivery system reforms.* Most recently the Administration has published a proposed rule on accountable care organizations (ACOs). This new delivery model aims to better integrate care delivery while also aligning providers' incentives. Other innovations planned for the delivery system are bundled payments and more attention to dual eligibles.

— *Working with states to establish new insurance marketplaces.* In the near future a series of regulations will be published to put in place the building blocks for health insurance exchanges.

Participant Discussion

- **Controlling costs.** While controlling costs was cited as a goal in reforming health care, Stuart Altman commented, "No one can look at the bill and say there is serious cost containment." He said the reason the various stakeholders all supported ACA was because "their ox didn't get gored." He acknowledged that had ACA contained serious cost containment, it probably would not have gotten passed. He said that Massachusetts shows what the future holds for the country: extending coverage has worked, but the state is now grappling with controlling costs.

Michael Hash disagreed. He said ACA contains half a trillion dollars in cost cuts, and no providers would say there are no cost cuts. Mr. Hash has seen tremendous enthusiasm from the provider community regarding delivery system reform and new models that better align financial incentives. Also, the creation of the Independent Payment Advisory Board (IPAB) is intended to help control costs. Mr. Hash argued that whenever he hears the criticism that ACA doesn't really control costs, he asks for credible ideas that could control costs, but he never hears any that aren't already included in ACA in some way.

- **Special interest buy-in.** Participants concurred with the point made by the panelists that securing the buy-in from special interests and stakeholders was critical to getting ACA passed. Even then, it passed by just the slightest of margins.
- **Presidential focus.** In 1993, health care reform was one of many topics that President Clinton tried to get done. In contrast, President Obama was more focused and tackled health care reform earlier in his presidency.
- **Election repercussions.** Chip Kahn commented that the victory in getting ACA passed was followed by a huge defeat in losing the House of Representatives.
- **Thank Newt.** Chip Kahn also suggested that in getting HIPAA passed in 1995-96, Newt Gingrich changed the legislative system so that the Congressional leadership dominated the process. The Democrats copied this model in getting ACA passed.

Session II: The Changing Private Insurance Market and the Role of States in Implementing Reform: New Federal Regulations

- Moderator: **Mary Ella Payne**, Vice President, System Legislative Leadership, Ascension Health
- Presenters: **Sherry Glied, PhD**, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services
Dan Durham, MPP, Executive Vice President, Policy and Regulatory Affairs, America's Health Insurance Plans
Len Nichols, PhD, Director, Center for Health Policy Research and Ethics; Professor of Health Policy, College of Health and Human Services, George Mason University
Stuart Butler, PhD, Distinguished Fellow and Director, Center for Policy Innovation, The Heritage Foundation

Overview

Now that the concepts of health care reform, such as realigning incentives and moving away from fee for service, have been debated and made part of legislation, the responsibility falls to regulators to write the specific regulations. But the details of these regulations—like the components in the essential benefits package and the algorithm for ranking exchange participants—matter immensely.

In the short term, insurers and providers are implementing the regulations that have come out, while preparing to comply with the longer-term regulations. But these activities are taking place in an environment with political uncertainty and uncertainty about whether these regulations will adequately control costs.

Context

The panelists discussed the implications of ACA on the health insurance market, the challenges associated with implementing ACA, and potential scenarios if cost savings are not achieved.

Key Takeaways

- **The legislative focus of health care reform was actually health insurance reform.**

In introducing this session, Mary Ella Payne observed that early in the debate about health care reform President Obama deliberately shifted his language to talk about “health insurance reform” as opposed to “health care reform.” Many of the most important and most controversial aspects of ACA—like the individual mandate and health insurance exchanges—are focused on making private health insurance work better.

- **Writing the regulations for ACA poses multiple challenges.**

Sherry Glied, as an assistant secretary at HHS, is involved in writing regulations for ACA. She described five major challenges in crafting these regulations:

- *The legislation didn't deal with the details.* For years those who focus on policy and politics have debated health care reform. But these debates didn't deal with specific and often mundane details, such as how to risk adjust insurance premiums when there are age ratings and multiple tiers of plans.
- *New regulations can't be divorced from running today's health care system.* The people working on these new regulations are the same people working on other, existing programs. These new regulations can't be divorced from the routine work that is taking place every day.
- *There is a lack of data.* Regulations are being written in areas where data does not yet exist.
- *Regulations must take into account America's diversity and variability.* In writing regulations, it is necessary, but complex, to confront the wide variability and the diversity of the country, including different health care and health insurance markets.
- *There is not much money.* Just \$1 billion was appropriated to implement ACA, which isn't enough for this task.

- **ACA provides states with tremendous flexibility in how the law is implemented.**

One response to these challenges that is built into ACA is to implement ACA in collaboration with the states. The law provides states with considerable flexibility and anticipates that states will implement provisions differently. This is based on the recognition that health insurance markets across the U.S. vary tremendously. The reason for such flexibility is to encourage experimentation by states, as ACA envisions states as laboratories for innovation, policy development, and implementation.

“Overall, the Affordable Care Act builds on and relies on the U.S. federalist structure: states retain significant authority, and with the help of federal dollars, can extend coverage and insurance protection.”
— Sherry Glied



A key area of state flexibility is around exchanges. States have considerable latitude in designing their exchanges, including the basic governance and organizational structure. Other areas with flexibility include selecting qualifying plans and policies to avoid adverse selection. Each area involves decisions with tradeoffs. States will have to decide what criteria to prioritize.

Good news about the implementation of ACA at the state level is there are considerable resources (\$2.8 billion) available to assist states, with more funding to come. Funding provides assistance in areas such as rate review, with rate review grants for states.

▪ **Private health insurers are implementing the near-term market reforms and preparing for longer-term reforms.**

Dan Durham, from AHIP, described what health insurance plans have been doing to implement the near-term reforms and outlined the planning taking place for more major reforms that go into effect in 2014. He also shared concerns that insurers have with some aspects of ACA.

Implementing ACA in the Near Term

Since ACA was enacted, insurers have been focused on implementing the Act's many near-term reforms. These reforms provide new benefits to members, including an internal appeals and external review process, no preexisting exclusions for children, coverage of preventive services, a prohibition on annual and lifetime limits, a prohibition on policy rescissions, and a requirement to cover dependents up to age 26. Also, health plans must now meet minimum loss ratio (MLR) requirements, meaning that just 15-20% of premiums can be spent on administrative costs or taken as profits. (The MLR rule allows states to apply for waivers; to date, 12 states have applied and three waivers have been approved.)

AHIP believes it would be prudent to transition to MLR requirements between now and 2014 to provide stability, ensure that plans stay in the market, and allow for more robust competition in health exchanges. Also, AHIP agrees that states are best suited to review rates, but finds the 10% rate increase that triggers a review to be an arbitrary threshold. AHIP is concerned this threshold will result in presumption of unreasonableness.

Major Market Reforms in 2014

In 2014 when health insurance exchanges are established, more significant reforms provide the promise of a more competitive insurance market. Major reforms include: guaranteed issue and renewability, so a person can't be turned down for coverage; a prohibition on preexisting condition exclusions; adjusted community rating of premiums; an essential health benefits package; and annual limits on cost sharing. These forms apply to plans offered both inside and outside of exchanges in the individual and small group markets; inside the exchange there are premium and cost-sharing subsidies.

For these reforms to work, ACA includes an individual coverage mandate which requires all people to be insured. Without such a mandate only high-cost individuals would be insured, premiums would escalate, and the market would be unstable.

While these reforms hold much promise, there are also significant challenges that include:

- *Premium taxes.* ACA imposes a tax on premiums for the fully insured market. CBO has estimated that these taxes will be passed on to consumers through higher premiums, which could total \$5,000 for a family over a decade. (AHIP would like this tax eliminated.)
- *Age rate compression.* The statute requires that premiums can be adjusted for age only by a 3:1 ratio. Yet in most states premiums today vary by a ratio of 5:1, and states allow rates to be adjusted by actuarial justification. In 2014, younger people will experience a significant premium increase, estimated at 35%. (AHIP prefers a 5:1 age band, or at least a phasing in of the age rating.)
- *Essential benefits.* Health plans in the individual and small group markets must cover a package of "essential benefits." The statute specifies 10 general categories of items and services as part of this essential package. Because of this greater level of mandated coverage, CBO estimates that average premiums in the individual market will have to be 27-30% higher in 2016. Increasing the cost of the essential benefits package will be a burden for small employers and can increase the cost of the government's subsidy.

"While it's important to have comprehensive benefits and an essential benefits package, it's also important to ensure that individuals and small businesses can afford the coverage and have a broad choice of innovative benefit design."

— Dan Durham



- *Underlying medical costs.* The country still faces the challenge of increasing health care costs, particularly from Medicaid, which will cover 16 million more people.

▪ **Incentive realignment is a critical part of health care reform.**

Len Nichols said that health care reform was based on recognition that the system had to change and was not going to change itself. There had to be a catalyst to signal that business as usual is over, because the country can't afford to keep doing things the same way. The country needs to either force spending cuts or realign incentives; health care reform is an attempt to realign incentives. The way ACA attempts to contain costs is:

- *Ending the profitability of risk selection.* The law makes it hard to have a business model that focuses on insuring healthy people and excluding sick people.
- *Getting providers to move away from fee for service.* ACA sends a strong signal to providers that the pay-for-volume world of fee for service is going to come to an end. The future will be about paying for value. Providers have received this signal and know that they will have to figure out how to deliver care at lower cost.



“What really matters is developing incentive structures that reward cost reduction . . . and improving quality.”

— Len Nichols

Implementing new incentive structures comes with challenges:

- *Uncertainty.* There is uncertainty around the 2012 election, which creates hesitancy to fully embrace health care reform. (Professor Nichols believes that if President Obama is reelected, ACA will not be repealed, but it will be amended and the expansion of Medicaid will be slowed.)
 - *Defining quality measures.* The most important link between insurance and delivery reform comes down to “What are we going to measure and report about quality?” Exchanges are required to rank participating plans by price and quality; the ranking algorithm will be critical.
 - *Determining the essential benefits package.* There is great trepidation on all sides about this package. The reality is that “we can’t afford what folks can imagine.” (The minimum benefit package required under ACA is a 60% actuarial value.)
 - *Engaging small businesses.* Today, small businesses are getting a bad deal in the small group market, yet they don’t trust government to fix this problem. They have to become engaged in devising the solution.
- **If in 10–15 years costs aren’t under control, the country will have a limited set of options.**

Stuart Butler envisioned 10–15 years after health care reform is implemented where costs are still not under control, which he thinks could be very likely. He envisions three potential options at that time, each of which entails a different relationship among the government, insurers, providers, and patients:

- *Option 1: Administrative State Strategy.* In this option, the federal government takes an even more active role in regulating and designing the entire health care system. This could involve cutting fees to providers and/or integrating clinical effectiveness research into payment decisions. (Currently, clinical effectiveness research can be looked at but has no teeth.) Under this

option, there would be more direct delivery system organization and a revival of the public option.

- *Option 2: Independent Commission Approach.* In this option, because of politics, an independent body with significant power would be established. (This is different from the Independent Payment Advisory Board, which has very limited power.) This would shift the locus of control away from Congress, resulting in a very different health care system. The NICE system used in the UK is an example.
- *Option 3: Global Budget.* This provides a defined budget for health care, which takes some oxygen out of the health system and brings down spending. Budgets could be established “top down,” which would mean determining a budget for Medicare, which would then have to be enforced. Or, a budget allotment would be given to the states for Medicaid (which is part of the Ryan plan). The belief is that a budget would force changes throughout the system as budgets would flow to providers. The other way to do this is by providing a budget to individuals through premium support (e.g. vouchers).

Participant Discussion

- **Expansion of exchanges.** Henry Aaron proposed an additional scenario: that health insurance exchanges get established, operate effectively, and enable people to choose between competing plans. Small businesses get better deals and large businesses begin to use exchanges. Over time, there is a gradual expansion of exchanges. Dr. Butler agreed that exchanges will be critical, as will be decisions about creating exchanges, such as where they are located and whether they are active or passive. (Dr. Glied sees exchanges developing differently in different states.)
- **Battle of ideologies.** Professor Reinhardt sees a battle of competing ideologies. One ideology is that the health system should be egalitarian, meaning that everyone gets the same health care. This ideology requires regulation. The other ideology is to ration health care by income class, the way that education, housing, food, and everything else is rationed. (Those who favor this ideology can’t bluntly state their philosophy.)

Professor Reinhardt sees one solution: a tiered system where the poor receive care in public hospitals and clinics; the middle class experience rationing through reference pricing; and the rich pay for boutique medicine. Dr. Butler agreed with the idea of a tiered system, but doesn’t think that it requires care to be provided by public institutions; premium support can allow poor people to be cared for in multiple facilities. (Stuart Altman pointed out that Professor Reinhardt’s concept currently exists in long term care.)

- **Rate review regulation.** This does not give the government the authority to regulate rates; it is really disclosure regulation. It requires insurers that have a significant rate increase to disclose this increase and to explain why it occurred.
- **MLR regulation.** Recently the trend in health care costs has been going down but insurers have continued to raise their rates because they fear that costs will go back up again. In the meantime, they are accumulating large profits and accumulating large surpluses. The MLR regulation says if you are accumulating more than you need, give it back. (Mr. Durham said the profits of health plans in the first quarter of 2011 were just over 4%.)
- **Paying for Medicaid.** Under ACA, Medicaid is being expanded, yet states already can't afford it and many providers are refusing to see Medicaid patients because the reimbursement is so low. Professor Nichols acknowledged that the country has to have "an adult conversation" about underpaying for the poor, and the federal government will have to pick up a bigger piece.

Other Important Points

- **The Secretary shall.** In PPACA, more than 3,000 times it is written, "The Secretary shall . . ."

Session III: State Health Exchanges

- Moderator: **Jon Kingsdale, PhD**, *Managing Director, Wakely Consulting Group*
- Presenters: **Anne Gauthier, MS**, *Senior Program Director, National Academy for State Health Policy*
Timothy Jost, JD, *Robert Willett Family Professor, Washington and Lee University*
Bruce Greenstein, MS, *Secretary, Louisiana Department of Health and Hospitals*
Sandra Shewry, MPH, MSW, *President and CEO, CA Center for Connected Health*
Alissa Fox, *Senior Vice President, Office of Policy and Representation, BlueCross BlueShield Association*

Overview

State exchanges have the potential to transform the markets for individual and small group insurance. The vision for exchanges entails providing consumers with more information and choices, along with more competition in the marketplace.

But implementing exchanges poses significant challenges. States are waiting on federal regulations and then must make decisions about whether to have an exchange, as well as the exchange's governance, purpose, rules, technology, and integration with Medicaid. Much must be done in a very short period to ready for the launch of exchanges in 2014.

Context

These panelists shared different perspectives on exchanges, highlighting potential benefits, expressing concerns, and identifying important implementation considerations and challenges.

Key Takeaways

- **Exchanges will transform the insurance market, but there is much to be done in a short period of time.**

Alissa Fox of the BlueCross BlueShield Association sees exchanges as transforming the insurance market. They will make it easier for consumers to shop for insurance, compare options, and enroll. Consumers will be empowered to "vote with their feet." For health plans, competing through exchanges in the small group and individual markets will require new products, business models, and ways of pricing and selling.

"Everything we do in the individual market and also in the small group market is going to change: how we price our products, how we sell our products, and even what our products are."

— Alissa Fox



The BCBS Association's perspective includes:

- *Focusing on state exchanges.* BCBS Association wants states to change their laws and adopt state exchanges. They are encouraged that so many states have enacted

legislation, have bills pending, or are enacting study bills.

- *Promoting competition and choice.* BCBS Association wants state exchanges to promote competition and choice by allowing all qualified plans that meet established standards to be allowed into an exchange. ACA's minimum standards for plans are extensive and offer significant consumer protections.

BCBS Association's concerns include:

- *Timing.* The challenge for plans is preparing for the launch of exchanges on January 1, 2014. Much has to be done by then, yet plans are still waiting on rules in areas like the essential health benefit package and risk adjustment.
- *System development.* Extensive system development is needed to create exchanges, but the specifications have not yet been set.
- *Affordability.* Offering affordable policies with new rules about the essential health benefits package, age rating, and medical underwriting will be challenging.
- *Standardizing plans.* BCBS Association is concerned about standardizing plans, because standardizing inhibits innovation and experimentation.

- **Consumer advocates see many issues related to exchanges that need to be addressed.**

Tim Jost laid out the issues that consumer advocates are looking at related to exchanges. They include:

- *Consumer friendliness.* Exchanges will succeed only if they are easy for consumers to use. They need to be attractive to consumers and insurers to achieve economies of scale. Premium tax credits and cost-reduction payments will only be available through the exchange, which will draw consumers in, but employers and individuals not eligible for subsidies will have to be convinced to participate.
- *Medicaid.* The basic idea behind the Medicaid and exchange interface is "no wrong door." An individual can apply to the exchange for assistance and be signed up for Medicaid or premium tax credits as appropriate. Eligibility will be determined using modified adjusted gross income.

Operationalizing the Medicaid exchange interface and determining eligibility (for Medicaid or premium tax credits) will be complicated. Also, one study predicts

significant churn from Medicaid to the premium tax subsidies and back, which is likely to affect access to and continuity of care. Also, because credits will be paid in advance and based on an individual's previous income, there will be situations where overpayment occurs and a "clawback" is needed. A family at 400% of the poverty level could owe \$3,500. (For many, the tax credit will be a loan, rather than a grant, which could cause frustration.)

- *Governance.* This is perhaps the most important issue to consumers. ACA permits states to establish an exchange either through a state agency or a nonprofit entity. States are doing it both ways. Consumers are also interested in who will serve on an exchange's governing board. A primary concern is conflict of interest if representatives of insurers or providers serve on the board. Advocates want consumer representation on the board, as long as they are legitimate consumer advocates.
- *Role of navigators.* The idea of a navigator is to provide individuals and small businesses with impartial information and to facilitate plan enrollment. Certification is appropriate for navigators, and navigators can be brokers and agents, but they don't have to be. Navigators are intended to reach populations that are not well serviced by agents or brokers.

Adverse selection is also an important issue. States need to regulate outside the exchange to prevent insurers from dividing the market by risk; this will be a problem in states with a federal exchange as the federal government has limited authority to regulate outside the exchange. Other concerns of advocates are: the ability of exchanges to engage in active purchasing; the availability of standardized products; the essential benefits package; plan rating systems; and enrollee satisfaction.

"It is essential that exchanges find ways to make coverage work for small employers."

— Timothy Jost

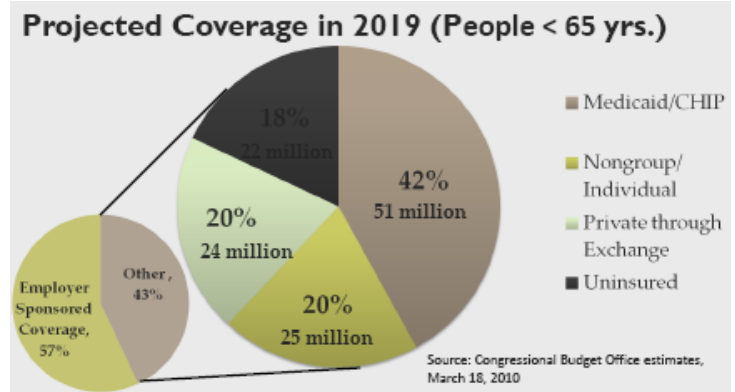


▪ **There are opportunities for states to think about exchanges and Medicaid together.**

At its inception in 1965, Medicaid was essentially a welfare program. However, it is expected that in 2019, Medicaid will be the insurer for more than 50 million people. But Anne Gauthier doesn't see health care reform as just expanding Medicaid; she also sees it as changing the market and reforming delivery.

The 51 million people expected to be covered by Medicaid is significantly more than the number expected to be covered through exchanges. It is expected that 28 million will shift between Medicaid and subsidized coverage in one year. Because of this shifting, it is important for states

to look at exchanges and Medicaid together and to consider:



- *Eligibility and enrollment.* Exchanges are required to determine eligibility for and coordinate enrollment in Medicaid and subsidy programs. In developing the IT systems to support eligibility and enrollment, exchanges and Medicaid are encouraged to share information, verify eligibility through electronic matches, and coordinate with other public programs.

While state exchanges are required to screen for eligibility, they are not required to enroll. However, a first-rate customer experience would be one where a consumer came to an exchange, found out if they were eligible for Medicaid or subsidies, were provided easy-to-understand choices, and could then enroll. This requires efficient, integrated processes.

- *Continuity of coverage and care.* The goal isn't just to enroll individuals; it is to provide continuity of coverage and care. This requires that states think about to what degree Medicaid should integrate with an exchange. States could elect to offer a minimum integration model where state agencies continue to contract with managed care plans, or could have a greater level of integration where the state purchases through the exchange. In addition, achieving continuity of care requires thinking carefully about benefit design and risk adjustment.
- *Purchasing/quality strategy.* States can use their power as purchasers in Medicaid and the exchange to achieve critical policy goals. Regarding states' quality strategy, there is an opportunity for states to develop a multi-payer approach to measuring quality that would include Medicaid.
- *Provider payment and supply.* The 32 million newly insured individuals who enter Medicaid will be competing for a limited supply of providers. These providers receive different payment rates for Medicaid and non-Medicaid patients, and have different networks.
- *Governance and infrastructure.* Governance of exchanges is a hotly debated topic right now as questions are discussed about the role of Medicaid and insurance agencies. Infrastructure systems and

information technology are also important as this is a time to bring old Medicaid systems into the modern world.

"There's really an opportunity for states to think about a vision for the exchange and Medicaid together."

— Anne Gauthier



▪ **California is proceeding aggressively to create its exchange.**

After ACA, California was the first state to enact exchange legislation. The governance model chosen by California is the state model. California will have a quasi-independent board with five appointed members and strict conflict of interest rules. Anyone affiliated with the health care industry is not eligible to serve on the board. California's legislation authorized the board to selectively contract with health plans, based on the best interests of individuals and small employers, to create the optimal combination of quality, service, choice, and value. (The board doesn't have to contract with plans, but has the authority to do so.)

California's legislation also has adverse selection protections, many of which are aligned with those in ACA. They include: an individual mandate; the availability of subsidies only through the exchange; uniform market rules inside and outside the exchange; one risk pool; risk adjustment; and establishment of an essential benefit package. In addition, in California, catastrophic plans are available only through the exchange, and language in the legislation requires fair and affirmative marketing. Important highlights in California pertain to:

— *Eligibility and enrollment.* In California, the exchange will be the first non-Medicaid agency to have the authority to enroll someone in Medicaid, which is a big deal. This is creating policy and operational tensions, as it is changing how the enrollment process occurs. Enrollment will be able to take place *through* the exchange, where previously decisions were made by a government employee. Dealing with eligibility and enrollment also means putting a process in place for vouchers.

— *Goals of the exchange board.* The exchange board must decide "What does it want to do?" Jon Kingsdale has talked about the need for the exchange board to think about being "an insurance store." But in California there is tremendous pressure from groups who want the exchange to tackle such topics as moving away from fee for service, improving the population's health status, and improving safety and quality. The board must determine what it wants the exchange to do.

"What does the governing entity of the exchange want to accomplish? Is it trying to align itself with public purchasers, perhaps with the Medicaid program, or private purchasers? Is it a one-stop shop?"

— Sandra Shewry



In addition, the board must make decisions about the exchange's accessibility (including hours, physical access, linguistic access); needs to consider the importance of efficiency, of being an active purchaser, and of benefit design; and must decide about outreach and marketing.

— *Role of navigators.* California has experience in this area with navigator-like programs already in place for Medicaid and SCHIP.

— *Self-financing.* The big question is how California can make its exchange self-financing by 2015. The law in California says the exchange is to assess reasonable and necessary fees to support the exchange. The exchange board will have to decide how much the fees will be and how to collect them.

▪ **Louisiana is not creating its own state exchange and is concerned about ACA's impact on Medicaid.**

In Louisiana, 27% of the state's population, or about 1.2 million people, are enrolled in Medicaid. Over the past year, 70% of all births in the state were paid for by Medicaid. About 20% of the state's population is uninsured, and the state's health system has received poor ratings. Therefore, viewing Medicaid as a safety net isn't accurate since one-fifth of the population falls through that safety net and still has to be served in some way.

Under ACA, in the first year of Medicaid expansion, Louisiana is projected to add 467,000 new people to its Medicaid rolls, which grows Medicaid by 40%. Of those new enrollees, 260,000 had no health insurance, which is what ACA was trying to accomplish. However, 187,000 people, representing 40% of all new enrollees, will come from private insurance. These are low-income people who have insurance and are paying premiums, but when given the option to enroll in Medicaid at no cost, they are likely to take it. (Mr. Greenstein believes health care reform was a missed opportunity to overhaul Medicaid, which was merely tweaked.)

Louisiana projects that by the end of 2014, Medicaid will be the largest insurer in the state, with 45-48% of all insured patients. As these individuals move to Medicaid it will have a major deleterious effect on private health insurance in Louisiana. Today Medicaid rates are not adequate and there is major cost shifting; providers receive low rates from Medicaid and higher rates from commercial payers. As consumers move from commercial payers to Medicaid, the impact on providers will be

significant. Commercial payers will have to raise their rates and will be reluctant to invest in long-term wellness and prevention programs.

"The idea of making such a broad expansion of Medicaid without understanding the true impact, with the level of rate cuts we've seen and with CMS's pressure to assure that rates are adequate . . . this puts states in a very, very difficult situation. We feel it's not well understood in DC."

— Bruce Greenstein



Regarding exchanges, Louisiana has decided not to participate. The state's leaders see the individual mandate as unconstitutional and don't want to engage in an unconstitutional activity. In addition, the timeframes are extremely aggressive and the state hasn't seen good guidance since ACA was passed.

Not wanting to wait for health care reform, Louisiana is implementing several major initiatives. Where possible, these initiatives are being done in collaboration with CMS. The state is moving into forms of managed care for its traditional population, is expanding behavioral health service, and has begun to implement pay for performance.

Mr. Greenstein sees the path forward as focusing on: simplifying eligibility criteria; providing choices for the same kind of health insurance products that state employees have, which would mean vouchers; and

blocking grants for states that want them, which would come with high levels of accountability.

Participant Discussion

- **Future winners.** A question was raised about which insurers will win under exchanges. Medicaid and Medicaid managed care are likely to be winners, if winning is measured by market share. Mr. Greenstein believes that if exchanges are like Travelocity, then small, localized, niche players have a chance of winning.
- **Time to implement.** In Massachusetts, the exchange was up and running about nine months after legislation was passed. The panelists believe state exchanges could be up in similar timing if the federal regulations are spelled out. Coordinating the relationship with Medicaid may be the hardest part.
- **Medicaid rates.** With the expectation of an enormous influx of people into Medicaid, the low rates paid to providers becomes an even more serious issue.
- **Medical home model.** To prepare to more effectively manage a larger Medicaid population, states need to adopt new delivery models. Ms. Gauthier believes that a medical home model shows much promise. Ms. Fox said 45 medical home pilots are underway among different BlueCross BlueShield organizations.
- **Conflict of interest.** Professor Nichols wondered if banning members of the health care industry from serving on exchange boards is necessary. An alternative would be creating boards with balance, where industry representatives can be outvoted if necessary.

Session IV: Should We Put the Brakes on Health Reform: Impending Challenges and Alternative Designs

- Moderator: **Charles N. Kahn III, MPH**, *President and CEO, Federation of American Hospitals*
- Presenters: **James Capretta, MA**, *Fellow, Ethics and Public Policy Center*
Tom Miller, JD, *Resident Fellow, American Enterprise Institute*
John McDonough, DrPH, MPA, *Professor of Public Health Practice, Harvard School of Public Health; Director, HSPH Center for Public Health Leadership*
Ron Pollack, JD, *Executive Director and VP, Families USA*

Overview

There are both strong supporters of health reform, who want it to become institutionalized, and opponents of health reform, who want to see it scrapped. Those in favor support the expansion of coverage and are in favor of policies like exchanges, Medicaid expansion, Medicare cuts, and an individual mandate. Those who oppose health reform don't believe it represents a desirable way to allocate resources, don't believe the country can afford another new entitlement, and are concerned about increasing power of the federal government. Both sides believe that the 2012 election will be critical to health reform's future.

Context

Ron Pollack assessed potential threats to ACA's repeal; Jim Capretta and Tom Miller offered arguments for why ACA should be repealed; and John McDonough identified inconsistencies in the positions of Republicans who opposed ACA.

Key Takeaways

- **Threats exist to ACA in the courts, in the legislature, and in the executive branch.**

Ron Pollack laid out the threats that he sees to ACA and offered his assessment on the seriousness of these threats. He noted that the challengers to ACA are not looking to repeal and replace it; they simply desire to repeal it. Therefore, the question is about the likelihood of repeal. The primary threats faced are in the courts, the legislative branch, and in the 2012 election.

Courts

About two dozen cases have been filed in district courts seeking to declare health care legislation unconstitutional because of the individual mandate. Thus far, most of these cases have been dismissed, largely on procedural grounds. Of the remaining cases, Mr. Pollack expects most to also be dismissed. Still, he ultimately expects a case to go to the Supreme Court, and it is impossible to predict how the Supreme Court will rule.

However, if the Supreme Court somehow rules that the individual mandate is not constitutional, the guaranteed

outcome provision and the underwriting provisions may be at risk, but the majority of the statute is unlikely to be in jeopardy.

Legislative Branch

This is where more significant risks of repeal exist based on what is taking place in Congress, particularly related to Medicaid. The topics being debated in the Congress that hold potential risks for ACA are:

- *Converting Medicaid to a block grant.* This is extremely unlikely, as it won't get through the Senate and the President would veto it. Also, it wouldn't be desirable for states, as the Ryan proposal cuts the funds to states by one-third in year 10.
- *Eliminating the "maintenance of effort" requirement.* Mr. Pollack doesn't believe that the Senate is likely to eliminate this provision.
- *Reaching a settlement about the debt ceiling.* This is the most treacherous areas for ACA. The risk is that an outcome of the debt ceiling negotiation is a formulaic cutback in overall government spending, which has a significant impact on Medicaid. This is a significant and realistic threat.

Executive Branch

The 2012 election will have a significant impact on whether ACA is repealed.

- **Opponents of ACA have a litany of reasons for the legislation's repeal.**

Mr. Capretta's argument for the repeal of health care reform was that this legislation doesn't allocate society's resources in the most effective, efficient way. In particular, Medicare will continue to be based on a fee-for-service system and there is no process in ACA to create a more productive, efficient delivery system that improves quality and decreases costs.

Mr. Capretta is skeptical about the effectiveness of ACOs, bundled payments, and other new payment model demonstrations. He cited previous experiments by CMS (like Centers of Excellence) aimed at improving the quality and decreasing the cost of care, which have failed. The way that ACA plans to decrease costs is by using the blunt instrument of capping Medicare spending and imposing centralized price controls.

"Are price controls, centrally managed through a bureaucracy, really the solution here? My answer to that is definitely no, but that is where we are headed."

— James Capretta



Mr. Miller also called for ACA's repeal, stating that it was not just a political or tactical game. He offered several reasons including:

- *Economic.* The country can't afford this legislation and it raises costs. Also, all of these resources going through the government will be incredibly inefficient.
- *A new entitlement.* This is a new entitlement on top of the old unfunded ones that aren't paid for.
- *Destabilization.* This legislation is destabilizing to the arrangements that were already in place and it jeopardizes the current health insurance system.
- *Administrative.* It is extremely complex and unlikely to work.
- *Federalism.* This legislation is being rammed down the throats of states.
- *Role of government.* This legislation gives the federal government more power, which is a slippery slope.
- *Not a policy priority.* With all of the challenges and issues that America faces, providing universal coverage is just not one of the country's foremost priorities.

"This is a new entitlement on top of the old unfunded ones that we haven't paid for yet and won't."

— Tom Miller



Among policy alternatives suggested by Mr. Miller:

- Solve the value problem first and then expand coverage.
 - Mainstream more of those in public coverage into private coverage.
 - Consider more elaborate defined contributions.
 - Consider continuous coverage incentives. This is the way to extend HIPAA portability in preexisting conditions and move people to the individual market.
 - Delegate allocation limits to private agents rather than public ones.
 - The safety net is important and ideas like real financing for high-risk pools should be considered.
- **For Democratic supporters of ACA, there are several Republican positions that simply don't make sense.**
- John McDonough raised five questions he has about Republican positions that he finds perplexing. These topics are:
- *Medicare.* During the debate about health care reform, Republicans were opposed to the \$450 billion in cuts to Medicare, even though these cuts were agreed to by much of the health care industry in exchange for expanded coverage. Republicans attacked Democrats during the 2010 election for supporting these cuts. But in the Paul Ryan budget, which was approved by all but four Republicans in the House, all of ACA was repealed except for the \$450 billion in cuts. So, it seems that Republicans were opposed to cutting Medicare in order to extend coverage, but are not opposed to cutting Medicare for budgetary reasons. This leads analysts to ponder exactly what is the Republican position on Medicare?
 - *Individual mandate.* This was an idea developed by Republicans, advanced by the Heritage Foundation, and embraced by numerous prominent Republicans, including Bob Dole, Newt Gingrich, Mitt Romney, and Jim DeMint. It was accepted by Republicans as part of the Massachusetts health plan and was not an issue during 2008 and 2009. It wasn't until Republicans like Senator DeMint attempted to make health reform President Obama's "Waterloo" that Republicans made the individual mandate political. The fact that Republicans are now opposed to the individual mandate, which was a Republican idea, seems solely political.
 - *Exchanges.* This was another Republican idea, supported by the Heritage Foundation, that Mitt Romney loved and made part of the Massachusetts health plan. In the health care debate, the White House and the House of Representatives wanted a single federal exchange, but the Senate insisted on giving states the right of first refusal to set up their own exchanges. Many states are moving forward in doing so. Yet, despite deferring to state rights, many are calling this a "federal takeover" and a "coming socialist apocalypse." Ironically, the only federal takeover of an exchange is if a state doesn't act.
 - *Comparative Effectiveness Research (CER) and end-of-life counseling.* CER was an idea with bipartisan agreement. End-of-life counseling was another topic that wasn't political in nature. In fact, in committee, Republican Senator Johnny Isakson proposed an amendment that would require anyone enrolling in Medicare to have first completed an advance directive for end-of-life counseling. This amendment was modified not to require beneficiaries to complete an advance directive, but to pay physicians more to provide end-of-life counseling. From these reasonable approaches to CER and end-of-life counseling came scare tactics about death panels and pulling the plug on granny. The bipartisan agreement that once existed is gone.
 - *Universal coverage.* For years, Republican Senator Kay Bailey Hutchison has said, "We all want health insurance for everyone," and "We all agree doing nothing is not an option." But the belief that Republicans truly wanted to

cover everyone has been shaken by efforts to repeal, and not replace, ACA.

"I just don't know where this [Republican] party stands anymore."

— John McDonough



▪ **Medicaid expansion is the key to the architecture for expanding coverage.**

Mr. Pollack sees Medicaid expansion as extremely important to the architecture of coverage. Today, Medicaid is a “miserly” program. The median income eligibility for parents is not 200% of poverty or even 100% of poverty; it is 64% of poverty. That means a family of three is ineligible for Medicaid if they have income in excess of \$11,860 per year. And, in many parts of the country the eligibility criteria is only 25% of the federal poverty level. The expansion of Medicaid is about allowing people earning up to 138% of the poverty level (\$25,521) to qualify for Medicaid. Some people are complaining that this is far too generous, but 138% of the poverty level is not very generous.

The biggest challenge is to make sure that those who are newly eligible for Medicaid or tax credit subsidies actually get enrolled. It should be a simple application, in multiple languages, with all options available through one portal.

"The biggest challenge is to make sure that we actually get the people newly eligible for coverage either through expanded Medicaid or tax credit subsidies actually enrolled."

— Ron Pollack



Participant Discussion

- **Vision or money.** The panelists were asked whether the political debate is really about a different vision, or about money. Mr. Capretta believes there is a different vision for health care and Mr. Miller believes that the parties have different values and priorities, which are aggravated by the country's current financial situation. Mr. Pollack believes the arguments are about both vision and money. Mr. Kahn said that even Republicans who wanted to expand coverage were never willing to commit significant funding to do so. Therefore, he believes the debate is ultimately about money.
- **Political support for Medicare.** In Mr. Capretta's view, previous experiments by CMS to steer patients to high-quality, lower-cost providers have failed because

politicians find it difficult to support a system that classifies any provider as low quality. It is easier for politicians to simply reduce reimbursement for all providers than to pay any providers less. For all of the talk about quality, the Medicare cuts in ACA are across-the-board cuts.

- **Premium support.** Paul Ryan has proposed moving Medicare in a different direction through premium support. The President rejected this idea, saying that in 2022 this would cost seniors \$6,500 more than Medicare fee for service. This number is the CBO's estimate of the difference in 2022 between Medicare fee for service and a privately insured plan under Medicare. Mr. Capretta said that in 2010, a privately insured Medicare plan cost just 97% of Medicare fee for service, yet the CBO is projecting that in 2022 the cost of a privately insured Medicare plan will be 130% the cost of fee for service. The reason is because the payment rate reductions in ACA make the fee-for-service care package look cheaper.
- **Election loss.** Each panelist was asked for their reaction if their preferred candidate/party were to lose the election. Mr. McDonough said that if his preferred candidate were to lose, he would simply go forward and do the best he could. He also said that the battle would shift to the states, hoping to find other states like Massachusetts that would be models. Mr. Miller said that if his party were to lose, it would mean that much of health reform would be likely to become institutionalized.
- **Health reform builds a platform.** Mr. Pollack acknowledged that ACA is not perfect legislation. But Social Security wasn't perfect when it was initially enacted in 1935. However, it provided a foundation and a platform that has evolved over time. ACA provides a platform for health care.

Other Important Points

- **7.5 minutes.** During a recent presentation, Mr. McDonough logged onto the Massachusetts Health Connector and went through the process of registering—which took just 7½ minutes. He compared the process to pumping your own gas.
- **Enroll America.** This is a new organization designed to make sure that systems are in place to help those who are eligible enroll in Medicaid and other programs.
- **Conservative generosity.** Mr. Miller mentioned research showing that conservatives give more of their own money in times of trouble; they are more generous with their own money but not with other people's money. The opposite may be true among liberals.

Session V: Future Health Care Spending: Political Preferences and Fiscal Realities

- Moderator: **Uwe Reinhardt, PhD**, James Madison Professor of Political Economy and Professor of Economics, Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University
- Presenters: **Paul Ginsburg, PhD**, President, Center for Studying Health System Change
Stuart Guterman, MA, VP, Payment & System Reform, The Commonwealth Fund
G. William Hoagland, VP of Public Policy, CIGNA
Henry J. Aaron, PhD, Senior Fellow, Economic Studies, The Bruce and Virginia MacLaury Chair, Brookings Institute

Overview

The United States is facing a major fiscal crisis. There is a near-term crisis as the debt/GDP ratio approaches 100%, and a longer-term crisis. If Medicare, Medicaid, and Social Security continue their historic rates of growth of GDP +2%, they will eventually represent the entire federal budget.

Actions must be taken to keep the debt/GDP ratio under 100% and to decrease the rate of growth in health care spending. Beyond just reducing the payment rates for Medicare and Medicaid, the panelists are interested in major changes like beneficiary cost sharing, premium support, all-payer systems, elimination of the health care tax exclusion, delivery system changes, and more. Some participants see raising taxes as a necessity.

Context

After the conference's first few sessions focused on implementing health care reform, this session looked at the country's fiscal realities, how health care contributes to these realities, and potential solutions for controlling costs and reducing the deficit.

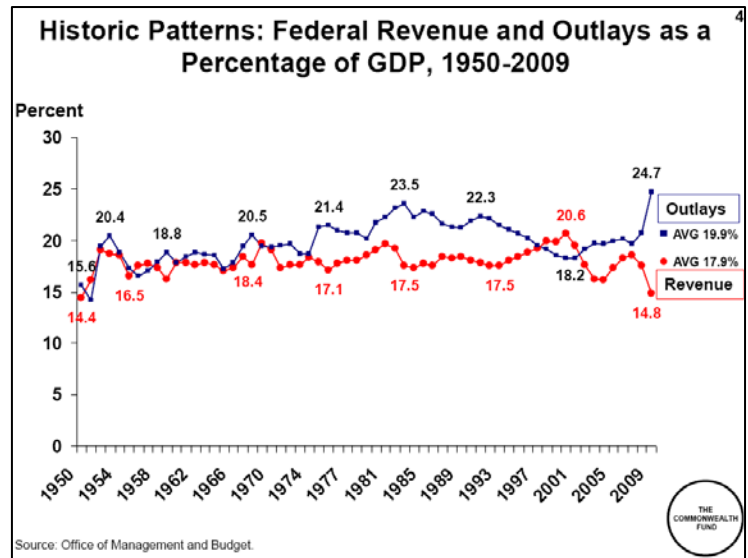
Key Takeaways

- **The United States faces a fiscal calamity.**

All of the panelists agreed that the United States faces severe fiscal challenges. Conceptually the problem is simple: spending and outlays significantly exceed the country's revenues.

Historically, the country's tax revenues have averaged about 18% of GDP, while spending has averaged about 20% of GDP. However, in the past few years revenues as a percent of GDP have fallen and outlays as a percent of GDP have increased, resulting in massive budget deficits.

The panelists also agreed that the country's ratio of government debt to GDP is approaching 100%, which is unprecedented, unsustainable, and extremely problematic.



- **There are differing perspectives on the causes of the fiscal calamity, but health care spending plays a key role.**

The panelists offered slightly different explanations for the country's deficits, but each sees health care spending as a key driver of the deficit, particularly over the long term. Among the deficit drivers identified by the panelists:

- *Non-entitlement spending.* Henry Aaron said the conventional wisdom—that the U.S. faces a big budget problem and that problem is mostly a health care cost problem—is simply not accurate. He said that the current budget problems and the debt/GDP ratio approaching 100% are not driven by entitlements. The sources are wars, Bush-era tax cuts, recovery measures, TARP, and the economic downturn—which will account for 100% of the deficit from 2009 to 2019. The sources of this deficit are not Medicare, Medicaid, or Social Security. (He acknowledged that health care spending is an issue over the long term, but doesn't see it as the source of near-term deficits.)

"The source of this problem [debt/GDP approaching 100%] is not entitlements. Growth of entitlements is negligible and is offset by the natural growth in revenues that is going to occur."

— Henry J. Aaron

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- *Attitudes and expectations.* Stuart Guterman said that budget deficits result from a lack of alignment between government revenues and outlays, which shows an unbalanced approach. Uwe Reinhardt sees a disconnect between the services that Americans want the government to provide and what they are willing to pay. As a result, the government provides more services than it can afford.

"The United States faces a fundamental disconnect between the services that people expect the government to provide, particularly in the form of benefits for older Americans, and the tax revenues that people are willing to send to the government to finance those services."

— Uwe Reinhardt

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- *Rising health spending.* Paul Ginsburg attributes the severity of the country's long-term fiscal challenge to rising health spending. While in 2010, Social Security, Medicare, Medicaid, and other health spending represented about 10% of GDP, by around 2050 they will represent roughly 18% of GDP, which equals historic levels of tax revenue. At that point, Medicare and other government health spending would account for 100% of the federal budget.

Mr. Guterman sees the problem as related to "excess cost growth" where health spending per Medicare or Medicaid beneficiary exceeds the rate of growth of GDP, as it has done by 2%. Professor Reinhardt shared data indicating that over the past decade the average annual medical cost for a family of four has grown by 8.8% per year, and now stands at about \$19,000.

"The driving factor in both public and private health spending is excess cost growth."

— Stuart Guterman

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- *An aging population.* Dr. Ginsburg said that the aging baby boom generation entering Medicare will exacerbate rising health care costs. Mr. Guterman shared data indicating that the aging population will increase federal spending, but not nearly as much as excess cost growth.

▪ **Multiple ideas and plans have been put forth to try to reduce the deficit and constrain health care spending.**

Mr. Hoagland's comment reflected the view of the panelists: "Fiscal realities necessitate that the rate of growth in public expenditures be curtailed." Panelists discussed the ideas in ACA to reduce spending, as well as

ideas in the Ryan Plan, the National Commission on Fiscal Responsibility and Reform (Simpson-Bowles), and the Bipartisan Policy Center Debt Reduction Task Force (Domenici-Rivlin). Also, panelists shared their own thoughts on the keys to controlling deficits and health care costs.

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- *Near-term deficit reduction.* Dr. Aaron argued that to keep the debt/GDP ratio below 100% over the next 10 years, the deficit will need to be cut by 4-5% of GDP during that time. He doesn't see that savings coming from Social Security, Medicare, or Medicaid during that time. He cited Paul Ryan and George Bush as previously refusing to make any abrupt benefit changes. So, in Dr. Aaron's view, over the next decade deficit reduction must come from defense cuts, cuts in discretionary spending, cuts in other mandatory programs, or by raising revenues (taxes).

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- *Containing costs through ACA.* Dr. Aaron doesn't see long-term savings from Social Security and believes savings from cuts to Medicare and Medicaid will be slow in coming. He is hopeful that the experimentation in ACA will result in effective long-term solutions.

Dr. Ginsburg believes that the most important cost containment strategy in ACA is the Cadillac tax which begins in 2018. He noted that the strategies for cost containment in ACA only focus on providers, which is in stark contrast to the strategies employed by private insurers, like cost sharing, tiered benefit design, and narrow networks. Also, ACA doesn't change the antiquated Medicare fee for service structure, and IPAB has limited tools and power to control costs.

"What is striking in the Affordable Care Act is how the Medicare cost-containment strategies focused entirely on provider and health plans and Medicare Advantage plans. There was a complete absence of beneficiary financial incentives, such as the incentive to choose more efficient providers."

— Paul Ginsburg

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- *President Obama's plan:* The President's plan sustains ACA, strengthens the IPAB, and limits Medicare's per beneficiary growth to GDP 0.5%. The burden to control health spending is placed on the IPAB.

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- *Paul Ryan's plan:* The Ryan Plan repeals most parts of ACA, keeps the Medicare cuts from ACA, phases out the traditional Medicare program, provides a defined contribution, and has beneficiaries obtain private insurance through a Medicare exchange. There has been some discussion of subsidizing low-income beneficiaries. There would also be block grants to states for Medicaid. The CBO has said this plan would save about \$2 trillion between 2012 and 2021. This plan puts the burden for controlling costs on individual consumers.

Initial opposition to the Ryan Plan shows the sensitivity of replacing Medicare, which has low administrative

costs, is able to get low rates from providers, and has the scale and credibility to try to reform provider payment.

— *Simpson-Bowles*: The plan, which deals with reducing the entire deficit, also includes ideas to reduce health care spending, but Mr. Hoagland doesn't see any specific policy proposals to control health costs other than an experiment for a defined contribution plan. It is projected to save around \$340 billion.

— *Domenici-Rivlin*: In Dr. Ginsburg's view, this approach is quite different from the Ryan approach. It continues traditional Medicare as the default program, unless people choose something else. It allows a rate of spending growth of GDP +1%. It also recommends phasing out the tax exclusion for employer-sponsored health insurance and transitions Medicare to premium support with a Medicare exchange. It also raises Part B premiums and bundles payment for post-acute care. Estimated savings from 2012 to 2021 are around \$250 billion.

— *Professor Reinhardt's thoughts*: Professor Reinhardt believes that the United States needs to:

- **Raise taxes.** In Professor Reinhardt's view, taxes are too low and should be raised. Currently the total taxes paid in the U.S. as a percent of GDP are the lowest among all developed countries. Those who oppose raising taxes say doing so will impede economic growth, but the data doesn't support this.
- **Shift to an all-payer system.** The only way for the U.S. to get a handle on health care costs is to shift to an all-payer system, like Switzerland or Germany. The alternative is severe rationing of health care by income class, where a tiered system evolves with one level of care for the lower class (with care provided through government physicians, clinics, and hospitals), reference pricing for the middle class, and boutique providers for the upper class.

— *Dr. Ginsburg's thoughts*. Dr. Ginsburg sees benefits from multiple approaches and therefore favors a blended strategy.

— *Mr. Guterman's thoughts*. Mr. Guterman wants policies that address underlying cost growth and change the way that health care is delivered and paid for. He advocates focusing on total health care costs (not just federal costs), protecting and/or enhancing access and quality; paying attention to distributional effects; emphasizing the need to improve performance; and creating all-payer coherence to align incentives. He also favors integrated policies that blend market-oriented approaches and social insurance values. He wants a mix of public and private, and wants more integration between Medicare and Medicaid.

— *Mr. Hoagland's thoughts*. Mr. Hoagland welcomes ACOs, value-based purchasing, comparative effectiveness, aligning payments, the new Medicare-Medicaid coordination office, MLR requirements, and

many other aspects of health care reform. However, he does not believe they will achieve the savings that are necessary. Changes are needed in provider and consumer incentives.

"There have to be fundamental structural changes both to the demand side of the equation and the supply side if we are to incent both consumers and providers to achieve a slower rate of spending"

— G. William Hoagland

- **Political agreement is needed to change the country's fiscal realities.**

The country's fiscal realities require action by the country's political leaders. However, Mr. Hoagland believes that the political realities mean there will only be marginal changes in the short term. He sees legislatures as limited by political realities and restrained by programmatic policies. After the big political shift in the 2010 election, Congress has become more polarized than at any point in the past three decades. He sees a high probability that the Senate will shift to a Republican majority in 2012 and attributes some legislative foot dragging to House members waiting for the 2012 election. (He disagrees with those who are posturing over the debt limit; he believes it is essential that Congress raises the debt limit.)

Dr. Ginsburg is somewhat more optimistic about the political situation. He believes that the severe budget outlook creates an alarming context where it will become more politically feasible to have budget-driven policy changes in health care and elsewhere.

Participant Discussion

- **Convincing the public.** Panelists noted that the public doesn't understand the severity of the fiscal crisis. They seem to believe that the deficit problem can be addressed without touching Social Security, Medicare, or Medicaid, and without raising taxes. Dr. Ginsburg observed that members of various budget reduction task forces had their perspective change once they were exposed to presentations that contained data about the severity of the problem. He wondered how to disseminate this information to the public in a digestible, understandable way.

- **Cost sharing in Medicare.** Stuart Altman raised the question of what the impact on the deficit would be if Medicare had cost sharing comparable to the level of cost sharing in commercial insurance plans.

- **Tax exclusion.** Simpson-Bowles and Domenici-Rivlin both recommend ending the tax exclusion for health insurance, and many politicians, particularly on the Republican side, have an interest in ending this exclusion. If this were to occur, there would be a significant drop in employer-provided health insurance.

Session VI: The President, The Public, and Health Reform

- Moderator: **Susan Dentzer**, *Editor-in-Chief, Health Affairs*
- Presenters: **Robert Blendon, PhD**, *Senior Associate Dean for Policy Translation and Leadership Development; Professor of Health Policy and Political Analysis, Department of Health Policy and Management, Harvard School of Public Health*
David Blumenthal, MD, MPP, *National Coordinator, Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services*

Overview

For presidents, policy decisions are about politics. These decisions are not about looking at general public opinion; they are specifically about understanding the opinions of voters, particularly voters who are likely to support them or whose support is needed. It is the opinions of Democratic voters, not all voters, that drove President Obama to prioritize and push for health reform.

Getting health care policies enacted into major legislation is about presidential leadership. It is about a president's personal passion and conviction, focus, timing, and skills in managing Congress and his or her own advisors. Health reform must be tackled immediately upon entering office when a president has a maximum amount of political capital, and health reform requires that the president be the spokesperson and the face of the legislation. Lessons from the Clinton administration's failure to pass health reform and from the successes and failures of other administrations were put to good use by the Obama team, who did a skillful job of managing the process to get health reform passed.

Context

Dr. Blumenthal, fresh from his role as National Coordinator of ONC, did not discuss health information technology. Instead he focused on the lessons from his book *Heart of Power* about the role that presidents play in health care policy, with a specific analysis of President Obama's role in getting the Affordable Care Act passed. Dr. Blendon described the role that public opinion, particularly voter opinion, plays in influencing policy decisions.

Key Takeaways

- **Health care reform requires assertive presidential leadership.**

President Obama's team carefully studied and learned from the failure experience of the Clinton administration in attempting to get health reform passed. However, Clinton was just one of a dozen modern presidents who have dealt with health care reform. Presidents who tried to avoid health policy have suffered versus those who have tried to engage and manage it.

Health care is a presidential issue. Significant health care reform only happens with assertive presidential leadership. There must be significant presidential involvement and extraordinary skill. President Obama and

his team showed tremendous skill in managing to get health care reform passed, as its passage was incredibly improbable. In fact, it may have been accomplished before the country was politically ready for it, but had President Obama waited, it probably would have been defeated.

"Nothing important happens in health care without assertive presidential leadership."

— David Blumenthal



Studying successes and failures from previous attempts to implement major health care legislation offers the following lessons:

- *The president must care passionately.* There are so many obstacles and reasons not to pursue health care reform that any president who chooses to take on this issue must be passionate about it. At multiple times President Obama went against the advice of his advisors and made health care reform his top priority. He "had health care in his gut," as did Lyndon Johnson, who led the enactment of Medicare. Bill Clinton cared about health care, but he let four or five other issues go first, which was his downfall.

Often a president's passion about health care is based on a personal experience or an experience of a loved one, as was the case for John Kennedy. This appears to have been the case for President Obama who upon signing the bill said, "I did this for my mother."

- *Presidents must act fast.* They must take on health care as the first issue in the first year of their first term, when they have their greatest amount of political capital. If not, the forces that oppose health care reform are so great they will defeat it.

Even though President Obama had to deal with stimulus, he did not wait. And even though he delegated the details of the legislation to Congress, he came with a general plan that had been developed during his campaign—which included using the private health care system.

- *Presidents must manage their economists.* Economic advisors will always raise red flags. They will say, "Let's get the economy straight," or "What about the deficit?" There will always be economic arguments to proceed incrementally, which is what Jimmy Carter tried to do. Invariably, when major health care legislation has been

passed, it has been because the president shows leadership and says to his economists, “We are going to do it anyway.”

— *Presidents must make the case to the public.* Health care is such a controversial issue that it can’t be done quietly. It must be taken to the American people, and only the president can do this. The president has to be the face of this issue and must offer an understandable explanation to the public. This is where President Obama was the weakest. He used his persuasive powers when he had to, but was not as effective as he was on other dimensions.

— *Presidents must manage the Congress.* Lyndon Johnson did this masterfully in getting Medicare passed. He outlined the major ideas he wanted, didn’t care about the details, and let Congress write the legislation. George W. Bush ceded the details of Medicare Part D to Congress and President Obama largely stayed out of the details.

In contrast, Jimmy Carter engaged in the details (in the margins of one memo he wrote “What about PSRO’s?”) and Bill Clinton delivered a detailed bill to Congress, as Congress had asked. (Dr. Blumenthal doesn’t believe Lyndon Johnson would have delivered such a detailed bill to Congress, even if he was implored to do so. He thinks Johnson would have said, “You write it,” because he knew then they would own it.)

— *Presidents have to know how to lose.* When Harry Truman lost on health care, he did so in a way that kept the issue alive and kept it as a legitimate issue that his party could continue to stand behind. But when Bill Clinton lost, he essentially vacated the playing field and left the issue to the opposition.

When President Obama decided, against the advice of his advisors, to continue forward with health care reform even after Scott Brown’s election to the Senate, he felt it was better to potentially lose the fight and keep health care reform as a Democratic issue, rather than vacate the playing field.

- **What matters is voters’ opinion, not general public opinion.**

Public opinion doesn’t make decisions. It is a “wind” that can help or hurt politicians, and it is subject to change. However, politicians don’t care about general public opinion. What matters to them is the opinion of voters, and in particular, the opinion of people who are going to vote for them.

This explains that passage of health care reform. At no time did the majority of Americans support ACA, but at all times during the debate, at least 75% of Democrats supported it. President Obama cared about the opinion of voters, and particularly those who voted for him. These voters wanted health care reform in the primaries and in the general election; it was their number-two issue.

“He [President Obama] did not enter into it [health reform] with a national mandate; he entered with a Democratic mandate to enact a bill.”

— Robert Blendon



Now, over a year later, the people who love the bill are Democrats and the people who hate it are Republicans.

- **Over the past decade there has been a big migration between the political parties.**

Conservatives are leaving the Democratic Party by the bus load; they no longer identify with the party. On the Republican side, moderates have become an endangered species. A result of this migration is that the Republican Party is now increasingly politically conservative. Within the Republican Party, the Tea Party is not a national takeover movement; it is a turbocharger to conservatives. These individuals don’t just disagree with the President about health care; they disagree with him about everything—the economy, foreign policy, taxes. The fact that the Republican party is more conservative and the Democratic party is more liberal makes it harder for the parties to make deals.

- **Voters’ opinions and the political migration explain the 2010 election results.**

In 2010, 38% of the American public said that they wanted ACA repealed. But 48% of all voters wanted it repealed and 78% of those who voted for Republicans for the House favored repeal. At the same time, 80% who voted for a Democrat for the House wanted ACA implemented; these people actually see the bill as “too wimpy.” The Republicans who favored repeal were angry and passionate; they saw ACA as a threat to the country. But the Democrats who saw the bill as too wimpy weren’t terribly emotional about the 2010 election. However, the key statistic is that 58% of Americans didn’t vote in 2010.

Looking ahead to the 2012 election, Dr. Blendon cited a model that predicts 18% more people will vote than in the 2010 election. Many of these 18% are independent swing voters. They will determine the winner in 2012 and the future of health reform.

Participant Discussion

- **Obama’s BlackBerry.** When looking back and analyzing lessons from President Obama’s management of the process to get health reform legislation passed, Dr. Blumenthal would be most interested in seeing the President’s emails to advisors that shed light on his thinking about decisions at key points in the process, such as deciding to press on after Scott Brown’s victory.

- **Political suicide.** Dr. Blendon sees the Ryan proposal on Medicare as political suicide. In 2010, the Republicans won a higher percentage of voters over the age of 60 than in any election since 1982. Yet on the heels of that momentum, they offer a proposal that threatens Medicare and has the potential to put fear into the minds of these older voters.
- **Swing voters.** Instead of talking about changing Medicare, Dr. Blendon predicts the Republicans will try to reframe the conversation to focus on the country's fiscal solvency, where they fare better with key independent swing voters. These swing voters don't understand and aren't very concerned about the debt ceiling. Because of the importance of these swing voters in the 2012 election, Dr. Blendon expects Republicans to hold out to the end in the budget negotiations and also expects President Obama to make significant concessions to appeal to these important voters, which will alienate some Democrats.

Session VII: Health Reform and Medicare: What Does it Mean for a Restructured Delivery System?

- Moderator: **Darrell Kirch, MD**, *President and CEO, Association of American Medical Colleges*
- Presenters: **Robert Berenson, MD**, *Senior Fellow, Urban Institute*
Jay Crosson, MD, *Director of Public Policy, The Permanente Medical Group; Senior Fellow, The Kaiser Permanente Institute for Health Policy*
Gary S. Kaplan, MD, FACP, FACMPE, FACPE, *Chairman and CEO, Virginia Mason Health System*

Overview

Everyone agrees that delivery system reform is essential, which must be accompanied or driven by payment reform that changes the incentives of providers. There is optimism that ACOs will help providers replicate what leading provider organizations like Virginia Mason are already doing: produce significant delivery system reform, more collaborative care, better quality, and lower costs. However, Dr. Berenson believes that proclaiming ACOs a game changer at this time may be premature; he also believes that significant cost-saving changes can be made within Medicare's current fee-for-service system.

Context

These physicians focused on delivery system reform and how health care reform legislation will help bring it about. They also discussed other ways to improve delivery systems and achieve cost savings outside of the ACA.

Key Takeaways (Berenson)

In talking about ACA and delivery system reform, Bob Berenson shared some views he termed as contrarian.

- **Medicare can reduce spending, even without wholesale delivery system reform.**

In Dr. Berenson's view, there is definitely a clear need for broad delivery system reform. Yet even in the absence of wholesale delivery system changes, there is much that Medicare can and should do to reduce spending. And when Medicare changes its basic payment policies or other policies, its actions can drive delivery system reform. Among the actions that Medicare can take to decrease spending and improve system performance are:

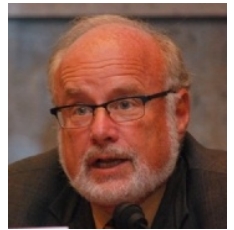
- *Collaborate with private payers.* Whatever the reality of cost shifting is between public and private payers—and Dr. Berenson believes there is some cost shifting—public and private payers share many common interests. For example, private payers often use fee schedules developed by Medicare. It would be desirable to see more private payer engagement in Medicare policymaking, such as RBRVS.

- *Pressure providers to operate more efficiently.* Providers often say that Medicare doesn't pay them adequately and therefore they have to charge private

payers more to get relief from cost pressures. But these complaints often are based on lack of discipline at hospitals that have market power. This market power leads hospitals to have weaker costs controls, higher costs per unit of service, and negative margins on Medicare beneficiaries. However, MedPac has found that "efficient hospitals" (those without the ability to generate higher prices from private payers) are able to cover 100% of their costs and break even from Medicare reimbursement. They produce high quality and have low cost per service unit.

"Payers, including Medicare, need to set rates so that hospitals feel some financial pressure to constrain costs. I think MedPac would argue that the current sort of pressure on hospitals, the deal cut by the ACA, was a reasonable one."

— Robert Berenson



- *Decrease spending variation.* Just on home health, DME, and hospice, the amount of regional variation in the use of services is astounding. For example, in Florida's Miami-Dade County the DME spending per capita for 2006 was \$2,200, while in Collier county it was \$220. In Mississippi, the live discharge rate for hospice participants is 55%, while it is 13% in Iowa. Wholesale delivery system variation isn't needed to decrease unwarranted variation.

- *Reduce fraud and abuse.* Fraud and abuse is a leading driver of spending and can be reduced without major changes to the health system. In FY 2010, CMS estimated that Medicare and Medicaid made more than \$70 billion in improper payments. Again, delivery system reform isn't necessary to substantially reduce fraud.

- **"Value-based purchasing" has been misapplied by CMS and Congress, and ACOs have gotten too much attention.**

In general, when Congress and CMS use the term value-based purchasing, they are often talking about quality reporting and pay-for-performance. This focus looks at how well providers perform what they set out to do, but largely ignores appropriateness. Also, in general, Medicare is largely precluded from considering value in coverage policies. There is limited use of comparative

effectiveness and no ability to support “coverage with evidence production.”

Since ACA’s passage, ACOs have been viewed by most as a “game changer” and have gotten much attention. But in Dr. Berenson’s view, ACOs were modeled after the PGP demo that was not particularly successful. The three-year PGP demo was not long enough for a delivery system to change its business model or culture. ACO shared savings is still fee for service. In reality, ACOs still require proof of concept. Viewing it as a proven game changer at this time is premature.

▪ **The Center for Medicare and Medicaid Innovation (CMMI) may be the most important part of ACA.**

CMMI has broad authority to test new things, including new payment models and new approaches to chronic care. It has a significant budget and the ability to perform multiple demonstrations on short timing. It is important for CMMI to develop a strategic plan that provides a vision of where it wants to go, to have some breathing room and be insulated from the pressure to push money out the door, and to focus on the scalability of successful demos.

Key Takeaways (Crosson)

Dr. Crosson focused his remarks on the concept of ACOs, which he sees as a vital part of delivery system reform, but which faces challenges and requires further development.

▪ **The goal for ACOs should be functional integration. Prospective payment is necessary to achieve this goal.**

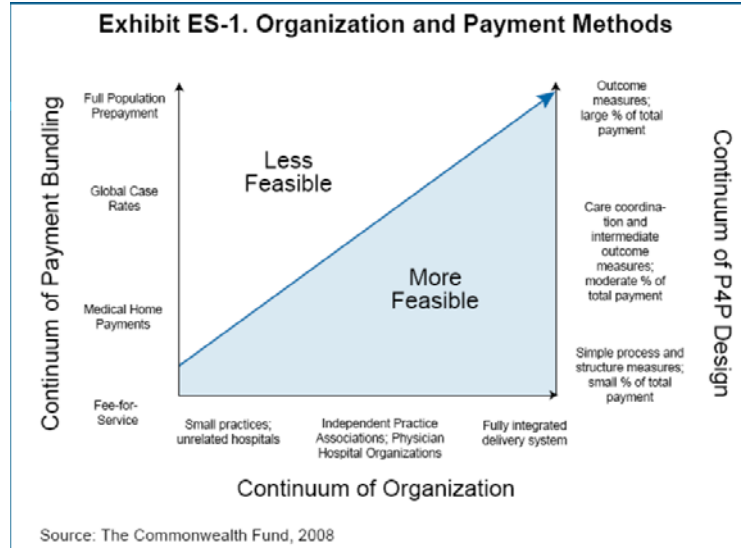
Dr. Crosson sees the ACO concept as much broader than just what is contained within the Medicare Shared Saving Program. The ultimate goal of ACOs is to create functionally integrated delivery systems that are capable of receiving prospective payment and are accountable for the quality and cost for a population.

“The goal is eventually to lead to at least functional integration, and I do believe that prospective payment is necessary if we are going to get to accountability for quality and costs in the general population.”

— Jay Crosson



The diagram below from the Commonwealth Fund looks at organization and payment methods. Today payment is largely fee for service and delivery is fragmented. The goal is to move toward more integrated delivery and more prospective payment.



The “Pioneer ACO Model,” which was recently announced by CMMI, is an attempt to bring prospective payment—essentially capitation—onto the table for those organizations that are ready.

▪ **In addition to including capitation, the Pioneer Model contains other important ideas.**

Dr. Crosson agreed with Dr. Berenson that the work of the CMMI will be critical, and sees the concept of the Pioneer Model as a start. Along with introducing the option of capitation for ACOs (which is being called “alignment”), there is also something for beneficiaries called “affirmative attestation.” While beneficiaries will be able to go wherever they want for care and will not be required to get their care through an ACO, affirmative attestation is a non-legally binding moral commitment by beneficiaries to receive their health care services from an ACO. (Dr. Crosson compared this attestation to the Pledge of Allegiance, which is not binding but is important.)

The Pioneer Model also requires multi-payer arrangements for outcomes-based payments and provides the potential for coordination with Part D plans.

▪ **Proceeding with ACOs requires addressing several important challenges.**

These challenges include:

— *Design issues.* The ACO model is built on the chassis of the Part A and B payment system, which provides beneficiaries with unlimited choice and doesn’t constrain beneficiaries in any way. This could be a major issue. (Dr. Crosson wonders if pushing beneficiaries to commit to an ACO for a year, or another period of time, would be as sensitive as committing to an HMO was.) In many instances, these are the same physicians and hospitals that individuals are already using.

- *Incentive issues.* Dr. Crosson finds it easier to envision workable payment incentives for physicians than for hospitals, where the business model is to fill up beds.
- *Payment issues.* The term “partial capitation” is being used, but it is not completely clear what is meant. It can mean having different degrees of capitation based on the breadth of risk incurred and the depth or degree of risk.
- *Having a good payer partner.* A big part of Kaiser Permanente’s success has been the partnership in place between the medical groups and the health plan partner. It is not clear if CMS will be able to form the same types of partnerships.
- *Physician leadership.* ACOs won’t work without trusted and committed physicians. This involves an ACO’s governance model and the relationship between physicians and a hospital. Shared saving does help align incentives.

▪ **Failure of the ACO concept has severe consequences.**

Dr. Crosson pondered, “If the ACO idea fails, what comes next?” The answer from other sessions at the conference has been that lack of cost savings from ACOs is likely to lead to across-the-board cost cutting, without consideration of the implications on quality. Dr. Crosson doesn’t see that as a system or a situation that anyone would want.

Key Takeaways (Kaplan)

Dr. Kaplan shared the experience of Virginia Mason (VM) Medical Center in Seattle over the past 10 years.

▪ **Over the past decade, VM has gone through a transformation in how it delivers care.**

Key elements of this transformation include:

- *Becoming truly patient focused.* Most organizations claim to be patient focused, but this is often just lip service. Virginia Mason determined that despite saying it was patient focused, its processes were not designed around patients. Over the past decade it has completely reengineered its processes to become more patient focused. This has involved a massive change in the organization’s culture which has included physician/administrator dyads and compacts between physicians and the organization’s leadership.
- *Focusing on improving workforce morale.* Health care in general has a serious morale problem among the workforce. Employees are being forced to work in chaotic situations with unreliable systems where they are not able to do their best work. VM has focused on creating an environment where employees can do their best work.
- *Eliminating waste.* Just reducing cost also reduces quality. The key has been focusing on reducing waste, which improves both quality and cost by creating care processes that are more efficient. In addition, waste is

eliminated when care decisions are appropriate and necessary. Appropriateness is about using evidence-based medicine.

- *Adopting a new management method.* VM had a strategic plan but didn’t have a systematic management method. After learning about the Toyota Production System, VM has adopted this rigorous, disciplined management system and the philosophies and practices associated with it. Its key elements are: put the customer first; deliver the highest quality; be obsessed with safety; create an environment where there is the highest staff satisfaction; and achieve high levels of economic performance.
- *Partnering with key employers.* An example is VM’s partnership with Boeing, which approached VM with a goal of reducing the health care cost for employees with chronic conditions by 15%, while improving these individuals’ health status. VM accepted this challenge, changed its care approach and delivery system to deliver care in teams, and partnered with two group practices in Seattle. As a result of these efforts, office visits went up by 6.7%, hospital admissions were reduced by 50%, and hospital days went down by 88%. Total costs for these patients declined by 33%, far exceeding Boeing’s goal; time away from work was reduced by over 50%; and participants rated the experience very favorably.

“We want to be a learning organization. This quote [by Eric Hoffer] captures my thoughts: ‘In times of change, learners inherit the earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists.’”

— Gary S. Kaplan



Boeing and other employers are interested in extending and broadening this program, which VM is doing with a shared savings model and with upfront funding from partners to help pay for the infrastructure costs.

▪ **ACOs show potential but come with risks. The solution is transparency.**

Virginia Mason appreciates the concept of accountable care because in many ways, VM has already been delivering accountable care, which is coordinated, safe, effective, patient centered, timely, and equitable. VM thinks of accountable care as delivering everything patients need, but only what they need.

However, from VM’s perspective, ACOs require significant upfront investment, provide limited upside opportunity, and require governance changes. Also, ACOs are likely to drive consolidation. Consolidation for the right reasons, which helps coordinate care, is positive consolidation. But consolidation that simply leads to higher market power and monopolistic pricing is bad consolidation. Dr. Kaplan

sees transparency as the key. There needs to be data that objectively shows employers and consumers about provider performance.

provide greater transparency. Employers must group together to create enough scale to push for transparency and delivery system changes.

Participant Discussion

- **Difficulty replicating.** There are a few leading organizations that essentially operate as ACOs—Kaiser Permanente, VM, Mayo, and Geisinger—but these organizations haven't been replicated. Several reasons were offered: the current payment system hasn't put pressure on providers or created a sense of urgency to deliver care differently; organizations haven't invested in IT and haven't employed pervasive management approaches, like the Toyota system; and other organizations haven't developed the deep collaborative cultures that exist in these organizations. Also, lack of pressure for transparency has meant that organizations haven't had to publish or be accountable for their results. Creating the type of culture that is necessary, developing IT systems, and creating full transparency takes significant investment and considerable time.
- **Employer power.** In most communities, individual employers aren't large enough to pressure providers to
- **Incentives override education.** A question was asked whether cultural changes can be brought about through changes to professional health and medical education. Dr. Kirch said that tremendous work takes place in teaching students about ethics and professionalism. But as soon as they see what the delivery system values and rewards, an erosion takes place. Even perfect education is quickly eroded. Dr. Kirch said that it is necessary to simultaneously redesign the delivery system, the incentives, and education.
- **Look at the VA.** The government is often criticized for its lack of efficiency, but over the past decade the VA has completely transformed its delivery system using IT and collaborative team-based care. Many lessons can be learned from the VA that apply to transforming the entire health care system.

Session VIII: How Will Health Reform Improve Quality and Increase Access?

- Moderator: **Karen Wolk Feinstein, PhD**, *President and CEO, The Jewish Healthcare Foundation and Pittsburgh Regional Health Initiative*
- Presenters: **Donald Berwick, MD, MPP**, *Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*
Christopher Tompkins, PhD, *Director, Institute on Healthcare Systems; Associate Professor, The Heller School for Social Policy and Management, Brandeis University*
Ziad Haydar, MD, *VP, Clinical Excellence-Physician Integration, Ascension Health*
Elliott S. Fisher, MD, MPH, *Director, Center for Population Health, The Dartmouth Institute for Health Policy and Clinical Practice*

Overview

There is much optimism that health care reform will bring about new payment models and delivery system changes that will improve the quality and decrease costs of health care. Health care reform provides tools, such as ACOs, that have the potential to transform care. But there are many challenges, including creating the right measures, fostering local partnerships between payers and providers as well as local collaboration between private payers, aligning and engaging physicians, developing transparency, and providing incentives that convince providers to move forward. CMS must provide a clear path forward that reduces provider uncertainty.

—*Strategic themes.* CMS is organized along four major themes. One is an internal theme of changing CMS's culture and systems to be a better partner. The other three strategic themes are external: improving care; assuring continuity of care; and focusing more on prevention.

—*Strategic plan.* CMS has developed a detailed strategic plan that is reviewed weekly with 19 elements.

- **ACA is a major policy shift to dramatically improve health care in America and provides numerous tools to do so.**

Dr. Berwick sees the progress being made in American health care as an irreversible, tectonic shift. He sees the Affordable Care Act as a policy shift taking place in two major phases.

Context

These panelists discussed how health care reform will bring about delivery system changes (particularly ACOs) and how these changes may affect the quality of care that is delivered.

Key Takeaways

- **CMS has clear, specific, and bold goals.**

Don Berwick described the big-picture goals and strategies put in place at CMS over the past year. These include:

—*The Triple Aim.* CMS's overriding goal is to create a health care system that simultaneously improves the care delivered, improves the population's health, and does so at a lower cost.

—*Trusted partner.* CMS has a new vision of being not just a primary payer, but a major force and a trustworthy partner for the continual improvement of health and health care for all Americans.

—*Guiding values.* CMS is driven by value structures and belief systems. The five values nurtured each day are boundarylessness, speed and agility, unconditional teamwork, a bias toward innovation, and customer focus.

Phase 1 – Achieving Health Security

This phase, which began in 2010 and will go through the middle of the decade, focuses on achieving security by making sure that everyone can get health care. A great deal of progress has been made in a short period of time. This includes covering children under the age of 26 on their parent's policy; closing the donut hole, and putting in place new benefit structures. Exchanges, Medicaid expansion, and subsidized coverage are all part of this phase. An important role for CMS is to ensure that the insurance industry behaves well in areas like the medical loss ratio and guaranteed issue.

Phase 2 – Improving the Health Care System

The search for health security cannot be achieved with the current health care system, as the current system is simply not sustainable. To create a sustainable system, either care has to be cut—which is not a desirable option—or the system has to be improved. There is much evidence that the current system can in fact be improved to realize the goals of the triple aim.

“We have a choice . . . to cut care or to improve care . . . can we rescue the American health care system by improving it I totally believe the answer is yes.”

— Donald Berwick



The solution is to make care seamless, coordinated, safe, patient-centered, timely, efficient, and equitable. ACA provides a toolbox to help improvement take place. Among the key tools:

- Accountable care organizations.* This is a key tool that if done right can make substantial progress in delivering more seamless care, but it is not the only tool. Getting it right requires striking balances on multiple dimensions, like seamless, coordinated care and open choice, or allowing hospitals to lead if they want to, or allowing physicians to lead if they desire.
- Focusing on dual eligibles.* The country's 9.2 million dual eligibles account for \$350 billion in expenditures. Today, only 100,000 of these individuals are in coordinated care and they all should be. ACA provides new tools and latitude for this group.
- The Innovation Center (CMMI).* Ideas can be converted into RFPs for contracts that have the potential to reduce cost and improve quality.

Other tools include bundled payment, value-based purchasing, medical homes, care transitions, more scrutiny for Medicare Advantage, the Star rating system, DME competitive bidding, and the Partnership for Patients, as well as the new umbrella of the Center for Consumer Information and Insurance Oversight.

In beginning to deploy these tools, it is important to be bold and optimistic, and to focus on rapidly scaling successful ideas.

- **Much can be learned from early ACO initiatives that can inform policy decisions moving forward.**

Elliott Fisher summarized some of the key learning from early ACO initiatives, offered his thoughts on the implications of this learning, and commented on other important considerations in the development of ACOs. His remarks are based on an evaluation framework for ACO implementation that looked at the performance of four pilot sites.

Key Insights

The evaluation of early ACO initiatives concluded that the mechanisms for ACOs will be important, which includes their governance, leadership, organizational structure, organizational capacities to engage in activities like care management, and use of technology. Also important is the social and cultural context for an ACO, which includes the community setting.

Less obvious insights were that for ACOs to work requires partnerships between payers and providers, and the recognition that accountable care is an ongoing process. By working in partnership, payers and providers can gain experience with different payment models, share data, and work together to measure performance. But it takes time to develop the trust that is required. For example, in some cases it took two years of conversations

between payers and providers until they were willing to share data. (CMS's recognition of the importance of being viewed as a trusted partner is important and could be transformative going forward.)

Implications

Understanding the time required for providers to get comfortable with accountable care sheds light on the reaction of most providers to the rules proposed by CMS for ACOs. In general, providers view these rules as too burdensome with too many measures, high upfront costs, and small returns. They feel uncertainty and are more comfortable staying on their current path.

"With all of the new payment models . . . if there is not a clear vision of where we are going I think many providers will feel it is safer to stay where they are."

— Elliott S. Fisher



To participate, providers need to see a clear path forward. They want clarity from CMS on opportunities and expectations in areas such as ACOs, episode payments, and medical home. Early participants (who will provide valuable learning) will need bigger rewards to induce them to participate. Also, there needs to be a common set of performance measures and ways to align with private payers. In addition, technical support is needed for providers, payers, and communities.

In terms of measurement, there need to be measures of the cost of episodes as well as health outcomes, patients' risks, and whether patients are getting informed choice.

Other important areas that must be addressed so that ACOs can advance are transparency around performance measurement and total costs, as well as structure that allow multiple stakeholders to engage in local conversations.

- **A major change in health care can be achieved with cost profiling for episodes.**

Chris Tompkins described how the intensity and cost of medicine are constantly increasing, which results in the underlying engine for medicine being transformed at higher prices year after year. It is not clear if these trends can be changed, or if the best strategy is to try to guide the system collectively, through approaches like shared savings. (Dr. Tompkins sees ACOs as a new label on an old concept of shared savings.)

For providers to innovate and try new approaches, there needs to be a community standard of medicine, so it is safe and so there is optimization around value.

An important step is to start doing cost profiling of hospitals, looking at spending per beneficiary at different time windows, like 30 or 90 days post discharge. A consortium led by Brandeis called PACES (Patient-Centered Episode System) will look at episodes, assess

them based on complexity, and build risk-adjustment models that are time dependent and continuously updated. PACES will look at what an episode is expected to cost for each patient based on their complexity and context. Each episode can be constructed and then all episodes can be rolled up and analyzed to look at expected versus actual results. A result can be creation of patient-level population metrics.

"This is bringing a mandatory message that we want value at the production of the hospitalization episode."

— Christopher Tompkins



This data can also be used to move upstream to avoid some of these hospitalizations and to provide scorecards to track what happens to patients downstream. This approach will help convey that medicine is a team sport and that accountability should be spread where it belongs.

▪ **The components of health care reform are having a significant impact on hospitals.**

Ziad Haydar described how various components of health care reform are impacting Ascension Health, a faith-based 70-hospital system with 116,000 employees. Among the most important components of health reform from Ascension's perspective are:

—*Coverage.* While Ascension must absorb almost \$3 billion in payment reductions from health reform, Ascension had to spend over \$1 billion last year for charity care, with almost 900,000 uninsured visits. Coverage expansion should help address this.

—*P4P.* Pay-for-performance has multiple dimensions including value-based purchasing, readmissions, and hospital-acquired conditions. Within value-based purchasing, performance on core measures will provide rewards to those providers that perform well and punish those who don't. The challenge that Ascension is experiencing is that physicians and management are struggling with the notion of "managing the metric." Physicians have to better understand the benefits of achieving positive scores.

The readmission component is forcing hospitals to think more broadly about what happens to a patient post discharge, which is a good thing. But translating this into practical programs to reduce readmissions has not yet occurred.

—*Accountability.* ACOs have much promise and Ascension is contemplating participation as a Medicare ACO in a few states, as well as possible participation in Medicaid health plans. In addition, Ascension is in conversations with commercial payers about shared savings programs.

Ascension's experience as a payer for its own employees and their dependents shows that an

organization that is accountable for population outcomes can reduce its cost trend, as Ascension has done. But doing so is challenging and requires a change in culture. It takes new covenants and compacts with physicians and a different approach. It also requires a transition plan that provides time for a hospital to change its fundamental business model that has been focused on maximizing the utilization of the hospital (termed by Dr. Haydar as "feeding the beast").

—*Cost reduction.* A major challenge is achieving cost savings through care coordination, not by cutting staffing, which could erode quality. Also, the focus on cost reduction (and on various process measures) has the potential to distract the organization from patient safety. Related to cost reduction is the need to better engage physicians in delivering more coordinated care, which is not easy.

"We are empowered by the emerging business models and compensation structures to say [to our hospitals] that you cannot cut all these good people because you are also financially accountable for these quality measures."

— Ziad Haydar



In addition, often overlooked in attempting to reduce costs is the reality that vendors engage in price discrimination, which drives up supply chain costs.

Participant Discussion

- **Incentives drive delivery.** Dr. Tompkins said that incentives drive an organization's function, which in turn drives its form.
- **Making fee for service less attractive.** Dr. Fisher said that more thinking is required to determine what makes it less attractive for providers to want to remain in fee for service.
- **Tiers.** Dr. Tompkins envisions a provider universe with three potential tiers. In the top tier would be organizations that participate in experimental payment systems like partial capitation or bundled payment. In the middle tier are organizations that are willing to be held accountable and participate in shared savings programs, but not in the experimental payment systems. The third tier would be providers who don't want to be held accountable. However, all tiers would be held to the same standards.
- **Local solutions.** When asked whether we will see more Kaisers, Dr. Berwick said that he envisions community-by-community solutions, based on the context within a community.
- **Patient enrollment in ACOs.** Providers are concerned that with no limitation on beneficiary choice, patients may move in and out of ACOs. Stuart Guterman observed that

the key may be creating positive incentives for patients so they will want to choose and stay in an ACO. He cited an expression that “the best fence is a good pasture.” He said that ACOs should try to entice patients to join and stay with them by providing better care, which they then communicate to patients.

- **Prospective versus retrospective enrollment.** Many providers are nervous about being financially responsible for a patient that is assigned to them retrospectively. They are much more comfortable with affirmative enrollment. Elliott Fisher indicated that data can be developed to show how frequently organizations move in and out of an ACO to determine whether this concern is a real issue.

Dr. Gary Kaplan commented that attribution after the fact is worrisome because it affects the patient experience. When patient attribution takes place upfront, a provider

can partner with patients in delivering programs that provide better care, as Virginia Mason has successfully done.

- **Changing threats.** Dr. Berwick acknowledged that in a fee-for-service world, the concern is overuse of services; in a shared savings model, the concern is underuse. That is why quality metrics are so important to ensure that quality care is delivered.

Other Important Points

- **What's in a name?** Karen Wolk credited Elliott Fisher with first using the term “accountable care organizations.” He says that he now wishes they were called “coordinated care organizations.”