THE U.S. HEALTH CARE SYSTEM IN TRANSITION

The 20th Princeton Conference

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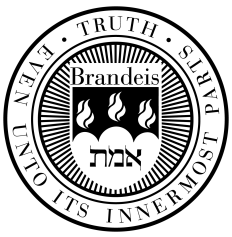

Stuart Altman, PhD
Chair, Council on Health Care Economics and Policy
and The Health Industry Forum

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The 20th Princeton Conference, *The U.S. Health Care System in Transition,* focused on how states are addressing health reform while facing huge economic challenges.

Moderators, presenters, and participants included key stakeholders who had working knowledge of how states are coping and what approaches they are using to address cost, quality, and access. This included barriers and possible opportunities presented by the Medicaid conundrum, high-cost beneficiaries, states' progress in setting up health insurance exchanges, and the role of federal and state regulations. Each session engaged well-informed participants in thoughtful discussion that included supporting and opposing views on how states should proceed with local health reform efforts.

With so many challenges and opportunities ahead for states, each conference session presented potential solutions and considerations that represent credible options as states navigate health care reform while addressing economic realities.

This policy brief presents the major findings from each session at the 2013 Princeton Conference.

Table of Contents

Session I: Health Care Spending Trends

- Presenters: **Joseph Antos, PhD**, *Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute*
  David Cutler, PhD, *Otto Eckstein Professor of Applied Economics, Harvard University*
  C. Eugene Steuerle, PhD, *Institute Fellow and Richard B. Fisher Chair, Urban Institute*
- Moderator: **Robert Reischauer, PhD**, *Distinguished Fellow and President Emeritus, Urban Institute*

Overview

There is agreement on the facts—that health care spending has slowed in recent years. But there is not agreement on the underlying cause for the slowdown: Is it largely due to cyclical economic factors or structural change? There is also disagreement about what the future holds, ranging from one perspective that the slowdown is structural in nature and future spending will come in far below projections, to a differing perspective that the slowdown was purely cyclical and that excess health care spending is likely to return to pre-recession levels.

Context

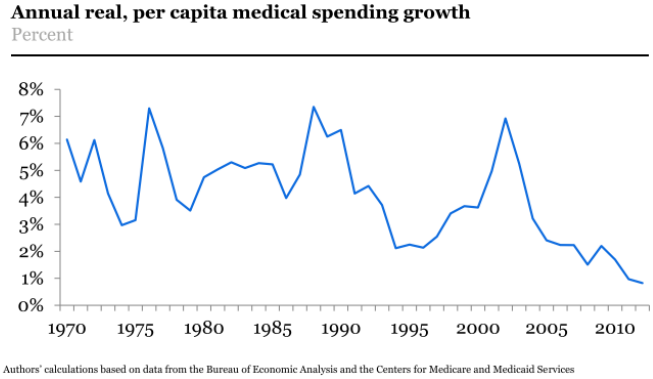
Robert Reischauer moderated this panel, which looked at trends in health care spending. The panelists attempted to explain what is driving these trends, and discussed their sustainability.

Key Takeaways

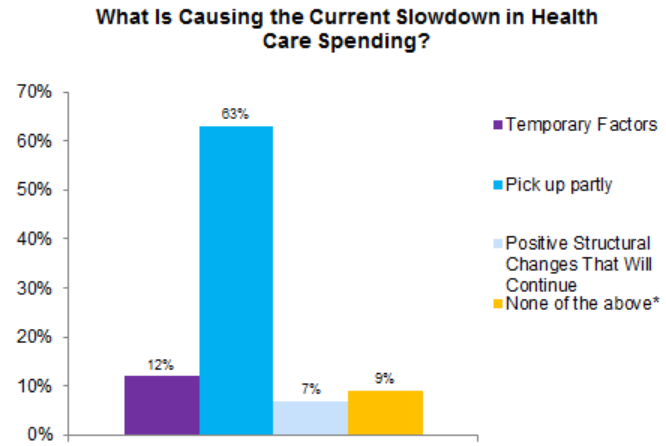
- **Health care spending trends have huge significance for the economy and for policy.**

  Historically, health care spending has grown about 2% faster than the overall economy; from the government's perspective, spending on health care has grown faster than general revenues. One result is that American workers have experienced anemic wage growth as rising health care costs have come at the expense of cash compensation.

  However, the panelists agreed that the overall economy has slowed as has health care spending in both the public and private sectors. The panelists have very different perspectives on how much of the spending slowdown is attributable to cyclical factors; how much is due to sustainable structural factors; and whether slowing spending is only temporary or is structural and will have a significant impact on future policy.



Among attendees surveyed, 12% see the slowdown as only temporary and believe that excess spending on health care will return to or even exceed long-run levels; 63% believe that spending will pick back up, but not to historical levels; and 7% believe the spending slowdown is largely attributable to positive structural changes that will continue.



Source: David Cutler survey of conference attendees

- **An argument can be made that the slowdown in health care spending is largely structural.**

  While conventional wisdom, supported by forecasts from the Congressional Budget Office, is that health care spending will take over the federal budget and ruin the economy, David Cutler doesn't see this occurring. He shared data showing that the per capita growth rate of medical spending is at the lowest level in recorded history and continues to decline. As a result of this low growth rate, real per capita medical spending over the past decade has been far below the actuarial forecast.

  Professor Cutler believes that perhaps one third of slowing in the rate of spending is due to the recession, with the rest of the slowdown due to structural factors including:

  — *Slowing of costly technologies.* Fewer expensive new drugs have been developed, many drugs have gone off patent, and the use of technologies such as imaging has slowed.

  — *Higher cost sharing.* A typical worker has a plan with a deductible of more than $1,000, which may be more than the worker has in his or her bank account. This means that any discretionary care would wipe out a consumer's savings, resulting in an overall slowdown in discretionary medical expenses.

  — *Greater provider efficiency.* Penalties have been imposed for hospital readmissions and hospital-acquired infections, which has caused hospitals to become more efficient to avoid these penalties.

Other structural factors include state-level policies to reduce the growth in spending, malpractice reform in some states, greater consumer engagement (though more information is needed to assist consumers), and the move to various alternative payment systems, such as ACOs and global capitation by private payers.

Taking all of these factors into consideration, Professor Cutler believes structural factors are playing a key part in slowing the level of health spending, and therefore, these lower levels of spending are likely to be sustained.

> *"There is at least as strong of a case for structural changes as for cyclical factors."*
> — David Cutler

- **An argument can also be made that the slowdown in health care spending is largely cyclical.**

Joe Antos is skeptical about whether there is any structural impact on the slowing rate of growth of health care spending, how significant any structural impact is, and whether any structural changes can be sustained. In looking at previous recessions and previous supposed structural changes, excess spending eventually returned to normal levels.

There are many arguments for why there may be structural changes taking place and why this time may be different. Reasons include changes in provider attitudes and how providers work, new types of delivery organizations, new financial incentives, and new marketplaces.

> *"You see all these things and other things you can think of and you say, 'Well, this might really be different.' But I wouldn't bet on it."*
> — Joseph Antos

But Mr. Antos outlined several reasons why he doubts that lower health care spending growth will be sustained.

— *Providers will respond to incentives.* They will lead changes, but will do so to protect their market share.

— *New work patterns don't guarantee savings.* More hospital-employed physicians, working shorter shifts, doesn't assure better outcomes or lower costs. There are more handoffs and just as many errors. And, HIT is only as good as the managers who use it.

— *Market consolidation is likely to increase costs.* ACA is already driving market consolidation. On the one hand, consolidation may improve care coordination, but the effect on prices is uncertain, and they may go up.

— *ACA will increase demand but not supply.* Many more people will have coverage and will demand care, but the supply of services won't rise much. As a result, costs may not decline.

— *The payment model is unchanged.* Fee-for-service Medicare is largely unchanged, as is employer-sponsored insurance. As a result, people still have an expectation that someone else is paying for their care and therefore will demand more.

— *Personalized health care has great promise, but could be expensive.* Personalize health care sounds appealing but lacks scale economies, making it expensive.

- **A separate argument is that focusing on excess cost growth is not the best variable; more important is looking at health care as a share of total and per capita GDP growth.**

Eugene Steuerle argued that while excess cost growth is important, it is a result of the "original sin in health care" which is the disconnect in the system between the party that receives health care (the consumer) and the party that pays for health care (the government or an insurer). He doesn't see excess cost growth being addressed until this model is changed. In looking at the slowing of health care spending, he sees that as a trend that has been repeated following every recession. He doesn't think it is possible to project whether these low levels of spending growth will be sustained.

Even more important, in Steuerle's view, is looking at the portion of the overall economy that health care represents. In looking at the past decade, health care costs absorbed almost all income growth; per capita GDP grew by $2,600 and health care costs grew by $2,300 per capita.

> *"The variable that I think we want to be looking at is the percent of per capita income growth that health care is absorbing."*
> — C. Eugene Steuerle

As health care spending grows as a percentage of the overall economy, in purely mathematical terms, the excess cost growth of health care can be expected to decline.

Participant Discussion

- **Setting state spending targets.** Some states have set spending targets and other states are contemplating doing so. Professor Cutler sees this as a challenging process (like a 10K race) but not extraordinarily hard (like winning a marathon). Mr. Steuerle argued that an open-ended target won't work, but a firm budget constraint can be effective. And, Mr. Antos sees no scientific way to set such a target. Rates of economic growth can vary quickly and significantly, while levels of health care spending are relatively stable and hard to quickly change.
- **Waste.** About one third of health care spending is not associated with improved outcomes. This spending could be eliminated and

directed toward innovation, with no negative results in people's lives.

- **Changing the retirement age.** Most of the growth in health care spending is for care for retirees. This spending and the care delivered make these individuals more capable. Unless the retirement age is adjusted upward, society is investing to increase capability but is not translating this capability into productivity for society.
- **Inequitable life expectancy.** Just as income is growing more dispersed, so too is life expectancy. Over the past two decades, growth in life expectancy has been almost entirely concentrated among the wealthiest one-third of society, with the most education. For individuals with just a high school diploma or less, life expectancy has stayed the same or fallen. It is difficult to create policies for essentially two populations of citizens.

Session II: Medicare Solvency

- Presenters: **Stuart Butler, PhD**, *Distinguished Fellow and Director, Center for Policy Innovation, The Heritage Foundation*
  Richard Foster, FSA, MAAA, *Chief Actuary, Retired, Centers for Medicare and Medicaid Services*
  Mark Miller, PhD, *Executive Director, Medicare Payment Advisory Commission*
- Moderator: **Elizabeth Fowler, JD**, *Vice President, Global Healthy Policy, Johnson & Johnson*

Overview

Although the Medicare trustees currently project that Medicare will become insolvent in 2026, two years later than estimated in last year's report, Medicare is not on strong financial footing as the program's total long-term costs are projected to exceed its income. Some parts of Medicare are already supported by transfers from general revenue, and future costs are likely to be much higher than are projected under current law.

Ideas to improve Medicare's financial status exist, but most proposals only address the level of spending, and not the rate of growth. One idea that needs to be considered is a long-term spending budget, possibly by using a beneficiary control approach where beneficiaries receive premium support or a defined contribution.

Context

This panel looked at Medicare's current financial situation and discussed ideas to improve Medicare's financial status.

Key Takeaways

- **In discussing Medicare's challenges, it is necessary to define the focus of the conversation.**

  In Rick Foster's experience, the concepts of solvency, budget impact, and sustainability are often confused, but are fundamentally different. He defined them as:

  — *Trust fund solvency.* This is whether the income of a particular fund is adequate to cover that fund's expenditures.

  — *Budget impact.* This has to do with whether Medicare adds to or subtracts from the overall federal budget deficit.

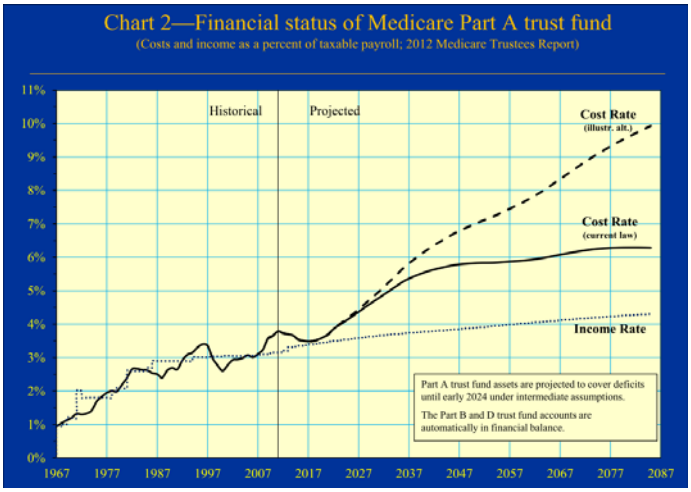
  — *Sustainability.* This is broader and deals with the question of whether the Medicare program can fulfill its intended purpose over the long run, at a cost the nation can afford.

- **Medicare Part A has long-term solvency issues, and Parts B and D are contributing significantly to the federal deficit.**

  The chart below, from the 2012 Medicare Trustees Report, shows that Medicare Part A's income is projected to continue falling short of expenditures, although by declining amounts for the next several years. After about 2017, the trust fund deficits would grow rapidly. At that point costs exceed income. Trust fund assets are projected to cover deficits until 2024. (The 2013 Medicare Trustees report estimates that assets will cover deficits until 2026.)

  However, under current law, income is only projected to cover roughly two thirds of Part A costs over the long term. And, in an alternative scenario, scheduled income would cover only about 40% of long-term costs. The conclusion is that under any scenario, Medicare Part A is not in financial balance and is not adequately financed.

  In contrast, Part B and Part D are automatically in financial balance (and Part C is financed out of Parts A, B, and D). The reason that Parts B and D of Medicare are in balance is because, due to statute, funds are transferred each year into Medicare from federal general revenues. So, these particular trust fund accounts are solvent, but because money is transferred from general revenues to provide the majority of financing, they are adding to the federal deficit.



- **Several aspects of current law are unlikely to be sustainable.**

  Mr. Foster described a few areas of the current law that he believes are unlikely to be sustainable. These include:

  — *Productivity adjustments.* ACA requires a reduction in the annual Medicare payment rate updates for most categories of providers, equal to the annual improvement in economy-wide productivity (estimated to average 1.1%), every year in perpetuity. Such productivity gains have not historically been realized in health care and achieving them is unlikely. If the law is unchanged, Medicare payments to hospitals, which are currently about 20% lower than payments from private health insurers (PHI), would become 40% less and eventually more than 60% less than PHI rates. The Medicare payment rate would even fall well below the current relative level for Medicaid. This is unlikely to be sustainable.

  — *Sustainable growth rate.* Under current law, Medicare rates are scheduled to be reduced over time to far below PHI and Medicaid rates. Most people believe that SGR is going to be replaced or continually overridden.

With these aspects of the current law being unsustainable, adjustments will have to be made, which will add to the costs that are projected.

> *"The actual cost for Medicare is likely to be greater than what was projected under current law."*
> — Richard Foster

- **Most of the proposals to reduce Medicare expenditures only affect the level of spending, and not the spending growth rate.**

Mr. Foster ran through a long and well-known list of ideas that have been proposed to reduce Medicare expenditures. Ideas include reducing waste and inefficiency, decreasing fraud and abuse, paying for performance, increasing the age of eligibility, converting to a premium support system, and many more. However, almost all ideas to reduce Medicare expenditures only affect the level of spending; not the growth rate.

Ideas with the potential to affect the growth rate include managing care, making delivery and payment innovations, increasing competition, having premium support with limited updates, converting to a global payment system, and adopting medical technology more prudently. The problem is that those ideas that are most likely to reduce cost growth are the most controversial and are the hardest to put in place.

- **MedPAC is exploring several ideas to try to contain expenditures.**

Speaking on behalf of MedPAC (the Medicare Payment Advisory Commission), which makes recommendations to Congress and the Secretary of HHS, Mark Miller described several areas where MedPAC is focused:

— *Provider payments.* Elements of payment policy the Commission considers when assessing Medicare's payments include:

  - **The level of payment**, which affects expenditures and sends a price signal to providers about which services to offer.
  - **The distribution of payments among providers,** which may be driven by factors in the payment system to favor or disadvantage providers for treating certain types of services and patients.
  - **Prevalence of fraud and abuse,** to identify where policies could be strengthened to ensure appropriate use and prevent erroneous spending.

One provider payment area the Commission has studied is how to address differences in payment rates when the same service is being paid differentially in multiple settings. In March 2012, the Commission recommended equalizing payment rates for clinic visits in the physician office and hospital outpatient department. Excessively high payment rates for certain services in the hospital outpatient setting were leading to the purchasing of physician practices by hospitals in order to bill for services at the higher rates. This has resulted in higher program payments and beneficiary cost sharing without additional value to the patient.

— *Medicare's payment rates and providers' costs.* It is often said that Medicare doesn't cover hospital costs and hospitals lose money on Medicare. But from MedPAC's perspective, costs are not immutable. MedPAC and other researchers have shown that providers with fiscal discipline can reduce their costs. When a hospital has less competition and is well paid by the private sector, it isn't as focused on operating efficiently and it has lower Medicare margins. But when hospitals aren't paid as well by the private sector, and are under greater fiscal pressure, they often operate more efficiently, and have better Medicare margins.

— *Payment policies to encourage coordination and restrain volume.* In a traditional fee-for-service Medicare, providers are paid more when they deliver more services, without regard to the quality or value of those additional services. They have no incentive to coordinate with other care providers and patients are not limited to providers who work together, which can lead to poor quality outcomes and greater utilization (and spending). While designing policies within FFS does not enable Medicare to entirely obviate those incentives, readmissions penalties and gainsharing are examples of policies that can encourage coordination, even in a FFS environment. Medicare's Shared Savings Program for Accountable Care Organizations (ACOs) is another example of a policy in FFS that encourages a greater focus on quality and resource use. To strengthen the current ACO program, MedPAC has suggested ACOs be required to share in both savings and losses with the Medicare program, instead of just sharing in savings. Also, further efforts to engage beneficiaries to encourage them to choose high-value care would be beneficial.

— *Policies to influence beneficiary decision making*. In addition to focusing on provider payment policies to improve care and constrain expenditures, MedPAC also considers the role of the Medicare beneficiary, whose individual decisions about their Medicare coverage options and their health care have significant implications for Medicare spending. In June 2012, MedPAC recommended that the traditional Medicare benefit be reorganized to provide a catastrophic cap and a schedule of co-payments instead of co-insurance. This change would give the beneficiary peace of mind that they are protected against very high medical expenses and also provide greater clarity on what their out-of-pocket expenses would be. That would lower the need to get first-dollar coverage through Medigap or employers. In addition to the benefit changes, MedPAC recommended requiring an additional charge on the purchase of first-dollar coverage, aligning the price of a supplemental plan more with the cost of the plan to the Medicare program.

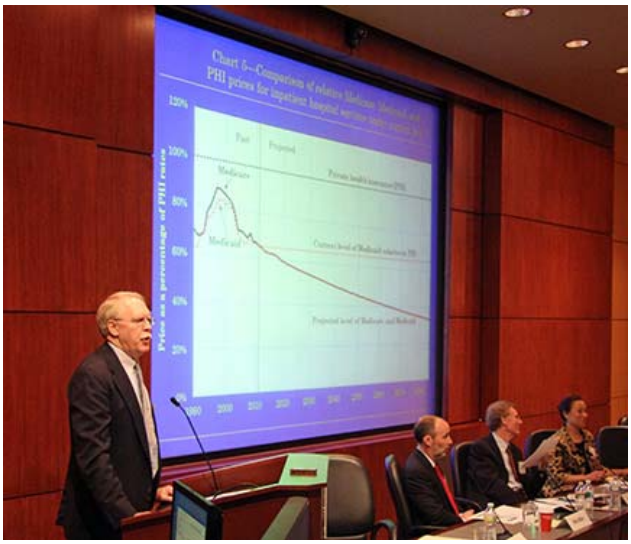
> *"Beneficiaries can have an influence on what happens through their choice of where they get insurance and at the point of service."*
> — Mark Miller

Through these recommendations, MedPAC hopes to have patients cared for by providers in more organized systems. At the same time, MedPAC wants Medicare to send signals to beneficiaries about the efficiency of various choices.

- **One idea to assure Medicare's financial stability: a firm, long-term budget.**

Stuart Butler believes there are good reasons to be skeptical about health care cost being controlled over the long term. And, if cost growth is controlled in some way, then Congress will be reluctant to take further action.

Believing that health care costs still need to be controlled, Mr. Butler recommends a clear, long-term budget for the publicly funded part of the health care system, particularly Medicare. Without a budget, Congress will never take actions that cause political pain, and health spending will remain on autopilot. Also, lack of a budget means there is no pressure on the delivery system to make changes or innovate, which would occur with a budget.



> *"Unless you think about how you would have a budget—a clear, default, strong, long-term budget—it's hard to think of a way we are going to solve this [Medicare spending] problem."*
> — Stuart Butler

Three basic approaches for a budget are:

— *Distributed to providers.* Funds would be distributed to providers, based on a budget, and the locus of decisions would move to providers; it would be their responsibility to work within this budget. This is what happens in capitated systems, and in Canada and the UK. There are questions about whether Americans would accept such a system.

— *Overseen by an independent commission.* In some ways, this is in the direction of the IPAB (Independent Payment Advisory Board), but the IPAB would have to become even more independent than it is today and would need far more power with regard to payment levels and prices. However, many individuals and people in Congress are reluctant to give the IPAB even the limited advisory role that it already has, let alone a more powerful decision-making role.

— *Making the beneficiary the locus of control.* This would entail putting in place some form of a defined contribution model or premium support, so that customers would receive funds to spend. In this model the goals would include a long-term budget that balances Medicare and other national objectives on a level budget playing field, dealing with and balancing the financial risks incurred by seniors in an acceptable way, and putting pressure on the health system to innovate.

In this beneficiary model, key design considerations include getting the basic amount of premium support right, having adequate risk adjustment, having a structure of information to enable beneficiaries to make good decisions, indexing for future growth, and dealing with the future of FFS.

Participant Discussion

- **Catastrophic coverage.** Since 1965, the basic Medicare benefit package has been largely unchanged (excluding the addition of Part D). However, lack of catastrophic coverage along with cost-sharing requirements results in huge numbers of bankruptcies. Medicare needs to look at revising the benefits to incorporate catastrophic coverage.
- **Separate funds.** One participant commented that having separate trust funds for Part A, B, etc. is pointless. To look at the overall budget impact and sustainability, there needs to be just one holistic point of view. (Another participant commented that most members of Congress actually don't understand that there are multiple, separate Medicare trust funds; the only thing they think about in terms of Medicare is Part A.)
- **Controlling costs.** One participant observed that approaches for controlling Medicare costs include scaling back benefits, but this is hard because there isn't much there; scaling back payments to providers, which is possible because the US pays more than other countries, but would unleash dynamics that wouldn't be pretty; and focusing on the impact of medical technology, which needs to receive more attention.
- **Enrollment systems.** Many low-income individuals who are eligible for certain programs don't get enrolled in these programs. So, there need to be automatic enrollment systems in place to help ensure that those who are eligible actually become enrolled.
- **Productivity defined.** In response to a question about how to define productivity, Mr. Foster said that, for Medicare payment purposes, it is appropriate to use a resource-based approach to productivity. He looks at the increase in services provided relative to the resources required to provide a particular service. Mr. Butler sees no good way to measure productivity, and said that just measuring the cost of producing things doesn't take into account whether the stuff that is produced is wanted and valued.
- **Low-income beneficiaries.** Participants expressed the view that any reforms adopted to achieve long-term sustainability should protect low-income beneficiaries from heavy out-of-pocket burdens.

Session III: Health Care Quality and Safety

- Presenters: **Kristine Martin Anderson, MBA**, *Senior Vice President, Booz Allen Hamilton*
  Christine Cassel, MD, *President and CEO, National Quality Forum*
  Susan DeVore, *President and CEO, Premier healthcare alliance*
- Moderator: **Karen Wolk Feinstein, PhD**, *President and Chief Executive Officer, Jewish Healthcare Foundation, Pittsburgh Regional Health Initiative*

Overview

In health systems across the country, measuring quality and improving care are priorities. The focus on quality and measurement, and linkage with payment, has gotten providers' attention. As the amount of data has increased there are numerous examples of quality-improvement initiatives that have produced positive results.

But participants see bureaucracy, confusion, an overwhelming number of measures, a lack of harmonization, and measures that aren't necessarily tied to outcomes or to what hospitals need to do in practice to improve care. Also, many of today's measures aren't producing the types of information that patients want.

There was agreement that there needs to be a shift from measuring processes to outcomes, and to more strategically using quality measures, measuring quality at the system level, and measuring the patient experience and providing data that patients care about. The focus on quality is still relatively new, much progress has been made in a short period of time, and despite the challenges, there was optimism about the role that measurement can play in driving improved outcomes and lower costs.

Context

This panel discussed the progress that has been made in measuring and improving quality and safety, the challenges that still exist, and the opportunities and priorities for the future.

Key Takeaways

- **Quality improvement can be driven by gleaning insights from data, and then taking action.**

  Founded in 1997, the premise of the Pittsburgh Regional Health Initiative (PRHI) is that dramatic quality improvement (approaching zero deficiencies) is the best cost-containment strategy for health care. When PRHI was founded, there was scant data, but a belief that 180,000 in-hospital deaths were occurring each year and 40% of every $1 spent on health care was not purchasing value. Over time, more data have emerged, which has led PRHI to focus on a series of initiatives.

  — *Lean thinking.* In other industries quality improvement has produced higher performance. The belief was that applying Lean thinking in health care could solve basic problems of quality and cost.

  — *Readmissions.* Data were produced showing that 1 of 5 patients discharged from a hospital returned within 30 days. With a focus on COPD (chronic obstructive pulmonary disease), it was found that readmissions often occurred because patients didn't know how to use their inhalers. A focused initiative decreased COPD readmissions by 44% within a year. Also, a separate initiative has focused on decreasing hospital readmissions among patients in skilled nursing facilities.

  — *Complex patients.* Data have shown that 5% of patients consume 50% of health care resources. Research on this 5% shows them to be individuals with chronic conditions, behavioral and substance abuse issues, or HIV/AIDS, or those near end of life and living in skilled nursing. Knowing this, PRHI focuses on bringing essential services and building system requirements into every level of care for these patient populations. PRHI's efforts have sparked demonstration projects, pilots, and other activities. (One program has produced a 50% reduction in hospital readmissions among those with HIV.) Also, tools are being used in primary care to identify substance abuse and depression problems and to do brief interventions, often producing dramatic results.

Among all of these initiatives and more, common themes have included being driven by data that shows where problems exist, and then proceeding to test solutions. As the amount of data grows, there will be more opportunities to identify opportunities for improvement.

"The frontier of quality improvement depends on making meaningful analysis out of this enormous amount of data that is out there now and is going to be democratized."
— Karen Wolk Feinstein

- **Overarching trends are defining opportunities to enhancing measurement and improvement of quality and safety.**

Having worked in the measurement and improvement area for 20 years, Kristine Martin Anderson shared four trends she is seeing. The trends are:

— *The digital revolution.* Adoption of HIT (health information technology) has increased, making the depth of clinical data that is now available much greater. However, the quality-measurement and quality-improvement enterprises still act much like they did when all of the data was on paper. More thinking and attention is given to data elements than data mining and analytics. The potential to integrate the measurement strategy with clinical decision support is speeding the cycle of improvement, and a major opportunity involves e-measurement.

— *Patients as consumers and users of quality measurement.* This is still early, but is gaining momentum. There is a push to allow patients to have more information and to supply patient-generated data, on topics such as functional status, outcomes, and experience. Once patients can direct the flow of information, they will have more control. Already, patients want information, but not the type of measures that providers want. And, they want personalized data. In particular, mHealth shows promise in engaging patients outside of the traditional delivery system.

— *Harmonization of measures.* The drumbeat for harmonization is getting louder, but it is not clear if we will ever get there. That's because there are different measures for different purposes and it is not always clear what the purpose of a particular measure is and what signal the measure is intended to serve. Positives in the harmonization discussion are general agreement that measures should be aligned with national priorities and the possibility that focusing on harmonization accelerates the move to measuring outcomes.

— *Expanding use of quality measures.* The increasing focus on measures is expanding the demand for new, innovative measures. A challenge is that the implementation timelines for new programs are often shorter than typical measurement development times, which tend to be slow. And, when new measures are developed, the areas of measurement are often complex and the measurements are largely unproven. We could use more realism here.

Conclusions regarding measurements include:

— *Tomorrow's measures will be different from today's.*
— *Tomorrow's users of measurement will be different from today's users.*
— *Tomorrow's measures will be developed through different processes.*
— *Tomorrow's performance improvement will be different.*

> *"Measurement exists to support improvement. We should be thinking about whether or not our measurement enterprise is working by whether or not our improvement enterprise is working."*
> — Kristine Martin Anderson

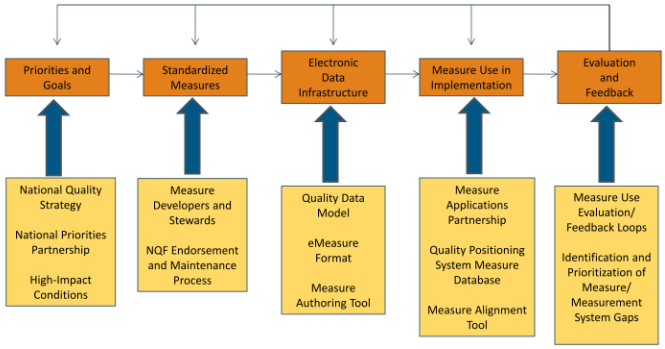
- **The quality-measurement world can serve health care and patients better.**

Christine Cassel, representing the National Quality Forum (NQF), reminded participants that you cannot improve what you do not measure. She acknowledged that there is currently a "signal to noise" problem as the health care world has innovated like mad, with many types of measures, for a variety of different purposes. This includes measures related to various policies, such as value-based payment and HIT, as well as payment based on public reporting.

In this context, NQF, which has only existed for about a dozen years and has made tremendous progress during this time, is working on the following activities: setting priorities and goals related to quality; standardizing measures; pushing for the creation of an electronic data infrastructure; seeing that measurements are put to use; and having an evaluation and feedback loop.

In addition, the National Quality Strategy's aims and priorities include health and wellbeing; prevention and treatment of the leading causes of mortality; person- and family-centered care; patient safety; effective communication and care coordination; and affordable care.

Challenges put forward by Dr. Cassel include the following: measuring population health; the alignment of public and private measurement; and understanding the best use of measures.



- **What really matters are measures that improve the care that is delivered.**

Premier's Susan DeVore said that her organization's members have given up on the idea of fewer harmonized metrics. They believe there will always be hundreds or thousands of metrics and some aspects of measurement will be bureaucratic. These hospitals accept that different measures will come and go; they are focused on practical measures that will help them deliver better care.

Working together, 350 health systems that are part of Premier have defined system-level measures along six dimensions, such as a composite harm score which broadly measures harm occurring within a hospital stay. Agreeing on these measures is a slow, hard process, as is implementing them. But once the measures are established and shared transparently within the cohort, there has been high acceptance and dramatic improvement. The best performers also have had dramatically slower cost growth, showing the ability to bend the cost curve.

Premier also is working on outcomes measures, cost measures, and experience measures. Premier has learned that when measures are in place and shared openly, there is usually quick movement to reach a top performance goal. This makes it extremely important, before putting new measures in place, to determine the intended use of data. Too often, rules and measures incentivize the wrong behaviors and distract from improving outcomes and lowering costs. Because Premier has structured the collaborative in such a way that all hospitals can reach top performance goals, rather than as a "tournament of quartiles" in which one's gain is another's loss, participants are eager to share successful strategies and to help each other improve.

> *"We've learned that the minute you set a measurement and make it transparent in your cohort and enable it with technology and collaboration, the numbers start to move."*
> — Susan DeVore

Participant Discussion

- **Changing the tone.** Often measurement is framed in an adversarial tone, with the implication that people are measured because they don't want to do the right thing and have to be measured and forced.
- **Measuring barriers.** One participant suggested measuring the barriers that exist to improving the quality of care.
- **System accountability.** Instead of measuring individual clinicians, measurement should take place at the level of organizations and systems. Systems will then work to make improvement.
- **Measures as signals.** Even if measures aren't perfect and can't be easily harmonized, they serve as a way of signaling priorities.
- **Broader measures of health.** One participant suggested not just measuring the delivery system, which is what today's measures focus on, but measuring health on a more holistic basis. Panelists commented that this hasn't yet occurred, but there is interest in the concept.
- **Ability to innovate.** A participant mentioned that federal regulations prevent a health system from being able to innovate in regard to what is being measured.
- **Teaching about quality.** In medical schools, there is little attention paid to the ideas of quality and measurement. Quality needs to be woven in the curriculum so that newly graduating physicians are prepared.
- ***Health Affairs* paper.** Several participants mentioned a recent paper in *Health Affairs*, co-written by Bob Berenson. This paper can be found by clicking here.

Recommendations in the Health Affairs *paper:*

1. *Decisively move from measuring processes to outcomes.*
2. *Use quality measures strategically, adopting other quality-improvement approaches where measures fall short.*
3. *Measure quality at the level of the organization, not the clinician.*
4. *Measure patient experience with care and patient-reported outcomes as ends in themselves.*
5. *Use measurement to promote the concept of the rapid-learning health care system.*
6. *Invest in the "basic science" of measurement development.*
7. *Task a single entity with defining standards for measuring and reporting quality and cost data, similar to the role the Securities and Exchange Commission (SEC) serves for the reporting of corporate financial data, to improve the validity, comparability, and transparency of publicly reported health care quality data.*

Session IV: Health Care Delivery System Reform

- Presenters: **Liora Bowers, MBA, MPH**, *Director of Health Policy & Practice, Berkeley Forum, UC Berkeley School of Public Health*
  Jay Crosson, MD, *Group Vice President, Professional Satisfaction: Care Delivery and Payment, American Medical Association*
  Bernadette Loftus, MD, *Associate Executive Director, The Permanente Medical Group*
- Moderator: **Karen Davis, PhD**, *Eugene and Mildred Lipitz Professor, Johns Hopkins Bloomberg School of Public Health*

Overview

Reforming the delivery system requires having a clear vision, strong leadership, physician engagement, necessary IT systems, appropriate financial and other types of incentives, and the right culture. Having these elements and implementing change is a significant challenge, but as case studies illustrate, it is possible. As organizations embark on becoming ACOs, they can learn valuable lessons from the successes and failures of other organizations that have already undertaken this journey.

Context

This panel discussed key elements of delivery system reform, drawing on personal experiences and case studies at the provider and state level.

Key Takeaways

- **It is beneficial to analyze the U.S. health care system in an international context.**

  In looking at how the U.S. compares to the health systems of other developed countries, the U.S. ranks last in health system performance in all dimensions of care. Other countries have universal coverage and no financial barriers to care. They use their leverage as a buyer of health care to get much better prices and they organize their care differently. They put much more emphasis on primary care and are way ahead in the adoption of information technology and on public reporting. They have bundled payment systems and hold providers and provider organizations more accountable.

  The U.S. is beginning to adopt some of these elements, as the Affordable Care Act moves toward universal coverage, begins to move away from fee-for-service toward value-based payment, and encourages greater innovation.

  From Karen Davis' perspective, we need more integrated delivery systems, and need to move toward global payment, bundled payment, and value-based payment.

- **Kaiser's experience in new geographies provides lessons as organizations embark on accountable care.**

  Dr. Bernadette Loftus described Kaiser Permanente's experience in the mid-Atlantic region, which differed significantly from the organization's experience west of the Rockies.

  In California, Kaiser owned its hospitals, skilled nursing facilities, hospice programs, and other key parts of the delivery system. But the structure in the mid-Atlantic region was very different. In that region Kaiser was not an integrated delivery system, lacked a coherent hospital strategy, had gotten away from its founding DNA, and was essentially operating as an indemnity insurer with 32 contracted hospitals and a fragmented delivery system. Kaiser was a smaller niche player in the market, without any negotiating power in contracting and without pricing power.

  To orchestrate a turnaround, Kaiser focused on:

  — *Strengthening infrastructure and capabilities.* Kaiser invested in IT and upgraded some buildings. The organization improved its in-visit population care systems and redesigned its performance reporting. It developed systems and processes related to access, patient satisfaction, quality, patient safety, hospital performance, and expenses.

  — *Changing the culture.* The organization focused on transferring its culture and know-how by importing seasoned leaders from California to the mid-Atlantic. There was a great deal of emphasis and investment on turning doctors into leaders.

  — *Changing relationships*. Kaiser re-dedicated itself to a strong primary care and ambulatory specialty care foundation and systematically redefined relationships with fewer hospitals, staffing them with Kaiser physicians.

  As a result of these efforts, Kaiser's mid-Atlantic membership, which had been in decline, is now growing, its plan ranking has dramatically improved, and its cost trends are much lower. The organization's reputation has also dramatically improved.

  Lessons learned from this turnaround experience include:

  — *Focus on execution.*

  — *Think big but start small. Move fast, create a sense of urgency, and make execution a core competency.*

  — *Some IT systems are essential.*

  — *The hospital partner is critically important. There must be aligned visions and values.*

  — *Physicians must believe they are practicing a better form of medicine.*

  — *The importance of culture change and leadership can't be underestimated.*

  — *Patient acceptance is dependent on them really feeling value*. If the patient can't tell the difference, it's not working.

  > *"Patients must be able to tell the difference between an integrated and an un-integrated care experience. If they can't, an ACO isn't working. If a patient has a longer drive or a narrower network, it must be worth it due to a palpably better experience."*
  > — Bernadette Loftus

  A danger is that ACOs will look like Kaiser mid-Atlantic did before its turnaround, as a fragmented delivery system without a clear

vision. But, with the right vision, systems and process, and culture, it is possible to deliver integrated, high-quality care at lower cost. Doing so takes leadership and a relentless focus on execution, quality, the patient experience, and costs.

- **ACOs need the building blocks of a successful culture.**

Dr. Jay Crosson observed that every presentation about the keys to ACO success have a bullet about "having the right culture." He also described having spent 25 years as a physician at Kaiser Permanente, and then immediately feeling comfortable upon visiting Geisinger, due to a compatible culture. This led him to define what elements make a culture successful.

— *Common vision/sense of purpose.* At Kaiser and Geisinger, Dr. Crosson observed that the physicians didn't talk about revenue or income; they talked about how they were organized to take good care of patients. This was their driving force in coming to work each day. There was a sense of shared accountability and common destiny.

— *Trusted governance.* This means the process to make structural, financial, and clinical decisions. In organizations with good governance, there is participation of physicians in decisions, and decisions are principled, have a sense of permanence, and are perceived as equitable.

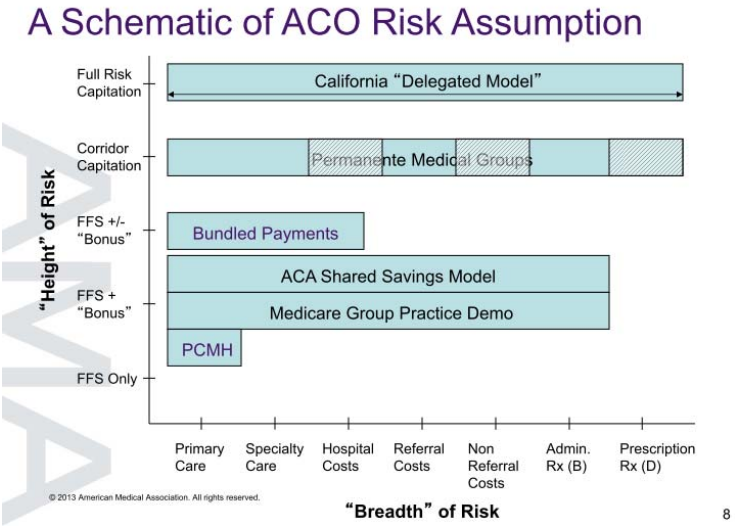
— *Effective physician leadership.* This doesn't just mean putting physicians into leadership positions. It means finding the right individuals in all levels of the organization. These individuals need to be multi-knowledgeable, understanding medicine, the business of health care, and leadership. They need to be identified and trained, and must be capable of creating "followership."

— *Effective management structure.* This management structure needs to be multi-level, with physician involvement at the facility level, the department level, and the level of committees and groups making important decisions. Cross-specialty collective responsibility is important, as is a matrixed model, with both clinical and administrative structures.

— *Sense of practice "sustainability."* Many physicians are dissatified with the current practice of medicine. The core issue is not financial, but is related to workload increases, administrative complexity that is taking physicians away from patient contact, scarcity of invisible capital, increasing pressure to seek hospital employment, and a feeling by physicians that "I just didn't do my job," which is the most corrosive element in the profession.

— *Balanced shared incentives.* The incentives have to be shared and aligned, and need to involve more than just financial incentives. In successful cultures, the incentives include quality, the care experience, and affordability, in addition to financial incentives.

The schematic below shows the direction that payment and delivery system reform could take, with providers taking both broader and deeper financial risk, and being responsible for greater amounts of care.



> *"As one moves up on this [chart] for any reason . . . the more likely it is that you're going to have an organization that ultimately succeeds. You don't have to go there in one step. An organization that doesn't have in mind progressive movement across this chart is probably not going to get where it needs to go."*
> — Jay Crosson

- **The Berkeley Forum is focused on improving California's health care system by using financial incentives to drive more integrated care.**

The Berkeley Forum brings together major players in California's health care system including payers, providers, and the public sector. This group published a report titled *A New Vision for California's Healthcare System*. The report showed that the state's health care spending is lower than the rest of country's, but is still significant. Lower spending may be attributable to a larger share of Asian and Latino residents, which tend to be lower utilizers as a whole, a younger population, and a large uninsured population, than the rest of the U.S. Controlling for these factors, however, still shows California with significantly lower utilization than the rest of the country, likely as a result of a greater managed care presence and a higher percentage of capitated payments in the state.

The Berkeley Forum's vision focuses on:

— *Payment reform.* The group supports a rapid move from fee-for-service toward global budgets, with a specific goal of decreasing fee-for-service from 78% of all health care dollars in the state to 50% in 10 years.

— *Integrated care.* The group supports a goal to double the share of the population receiving highly integrated care in 10 years, from 29% to 60% of all Californians.

— *Lifestyle and environmental factors*. The intent is to work with other sectors, such as education and housing, to promote and encourage healthier lifestyles.

This group also endorsed initiatives to increase value, improve care, and reduce long-term health spending in California. These initiatives are:

— *Global budgets and integrated care systems*

— *Patient-centered medical homes*

— *Increased palliative care access*

— *Increasing rates of physical activity*

— *Increasing use of non-physician providers, such as nurse practitioners and physician assistants*

— *Reducing the rate of health care–associated infections*

— *Reducing the rates of pre-term births*

Major challenges in achieving this vision and executing these initiatives include provider consolidation that leads to use of market power to hurt market competitiveness and declining enrollment in commercial HMOs (there has been a 20% decline, excluding Kaiser, over the past five years).

This group sees several important intermediary steps in achieving this vision. These include ACOs, the movement of dual eligible patients into managed care, and efforts to improve overall population health via collaborating with other sectors and with employers, many of which are already working to create healthier work environments.

The Berkeley Forum's website can be found at http://berkeleyhealthcareforum.berkeley.edu/

Participant Discussion

- **Historical perspective.** Stuart Altman offered a history lesson about three times since the 1970s when cost containment worked, if even for a short period of time: 1) in the early 1970s regulation flattened growth for two years until unions and Democrats feared that cost containment was going to affect wages and jobs, so regulation was removed; 2) in the mid-1970s the hospitals agreed to keep costs under control, which worked for a few years; and 3) in the 1990s managed care controlled costs—and it was hated. Providers hated being second guessed; patients were outraged at having care denied; the press wrote sensationalistic stories; and the politicians responded by taking the teeth out of managed care.

  The question is, "Is this time different?" There is reason to be slightly optimistic because the slowing of cost growth is not attributable to one specific thing; it is based on a confluence of multiple factors including improved safety, declining readmissions, a slowing of new technologies, a move away from fee-for-service, new types of incentives for providers, and efforts to better engage patients. This multiplicity of factors provides some optimism that the slowing of cost growth may be real.

- **Continuous savings.** Often it seems that one-time savings opportunities are dismissed. However, Karen Davis emphasized that it is possible each year to find different one-time savings opportunities, which in aggregate, can make a significant difference.

- **Beneficiary incentives.** There are multiple ways that beneficiaries can be given incentives to seek care from high-value providers. There can be a restructuring of benefits and tiered networks of providers, with different financial structures that incent beneficiaries to seek care from those that provide the greatest value.

- **Developing leadership.** While Kaiser could transfer leaders across geographies, not all organizations will be able to do this. It will be necessary to bring in established leaders, hire consultants, and invest in training to develop leaders.

Session V: Next Steps in Cost Control

- Presenters: **David Blumenthal, MD, MPP**, *President, The Commonwealth Fund*

Overview

Even with the slowing rate of health care cost growth, overall health costs remain an enormous issue. Part of the problem is that successes take place on "islands of innovation" and are slow to spread, as the health care macrosystem is not conducive to change. However, the Affordable Care Act has numerous policies and programs aimed at changing the macrosystem, with changes to payment policies that emphasize value.

But the amount of change taking place is confusing and overwhelming. Needed are frameworks to synergize various policies and stabilize costs. A shared consensus is emerging across the political spectrum on approaches to control costs.

A particular area for optimism is the adoption of electronic health records, which is far outpacing projections.

Context

David Blumenthal, currently president of the Commonwealth Fund and previously the National Coordinator for Health Information Technology, summarized the health care cost problems that face the United States and offered strategies for confronting these problems.

Key Takeaways

- **Even if the optimists are right and the rate of cost growth is slowing, the cost of health care remains a pressing problem.**

  Health care spending in the U.S. would rank fifth in GDP among the world's economies. It is far larger than any other sector of the U.S. economy. And, the opportunity cost for the excess spending on health care has been enormous. Had the per capita spending in the U.S. been equal to the per capita spending in Switzerland —which has the second highest per capita spending in the world after the U.S.—the U.S. would have saved $15.5 trillion between 1980 and 2010. This would have been enough to turn the $11.6 trillion national debt into a $3.9 trillion surplus, or send 175 million students to a four-year college for free, or pay for enough solar panels to take care of the energy needs of the United States, or purchase four iPads for everyone in the world. Much of this spending—at least 30%—is due to waste. Sources of waste include failures of care coordination, administrative complexity, and pricing failures.

- **The performance of the health system is influenced by two systems: microsystems and macrosystems.**

  Microsystems include places where patients and clinicians receive and provide services, such as physicians and hospital managers, as well as admitting departments, ICUs, doctors' offices, nurses' offices, and catheterization suites.

  Macrosystems include payment systems, the insurance industry, government regulations, how providers are accredited, and other factors that create a "force field" in which providers and patients come together. Dr. Blumenthal asserted that most providers are unaware of macrosystems.

  A great deal is known about microsystems, There are islands of excellence—including areas like computerized decision support, reminder systems, continuous quality improvement, computerized provider order entry, and a range of other innovations that have been tested and proven to have a positive impact on care. But the problem is that these innovations don't spread. And the reason these successful microsystems haven't spread is because of failed macrosystems.

> *"We haven't created the systems that would make it easy to do the right thing and then make it compelling to do the right thing."*
> — David Blumenthal

  The Affordable Care Act (ACA) is mostly about changing the macrosystem in which providers and patients come together. CMMI can take positive changes in payment and spread them quickly, without Congressional authority. Macrosystem changes set forth in the ACA include reduced payments for avoidable complications, value-based purchasing, Medicare Advantage plan bonuses, bundled payments, physician quality reporting, hospital quality reporting, medical homes, and accountable care organizations (which were actually part of separate legislation).

> *"The Affordable Care Act . . . is the most complete toolbox we have ever had at our disposal in the history of our health care system."*
> — David Blumenthal

- **With so many changes to macrosystems occurring simultaneously, synergistic policies with broad political support are needed to stabilize costs.**

  While the many new tools and programs to control costs are exciting, this wealth of tools also poses a problem. The number of changes taking place simultaneously is incredibly confusing to health care organizations. They don't know which to pay attention to, what to prioritize, and which will have the largest impact on their budget.

  To help make sense of the many changes taking place, the Commonwealth Fund authored a report titled *Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System*. The goal of this report was to create incentives and structures for better care and lower cost throughout the continuum of health care services. The report recommended three basic strategies for macrosystem change. They are:

  — *Payment reforms to accelerate delivery system innovation.*
  — *Policies to expand and encourage high-value choices by consumers of care.*
  — *Other actions to improve how health care markets function.*

On similar timing as the Commonwealth Fund's report, several other reports were published that focused on how the health care system should be changed, especially on the cost side. These included reports from the Bipartisan Policy Center, Brookings, the Center for American Progress, the National Coalition on Health Care, the Partnership for Sustainable Health Care, and Simpson-Bowles. The Commonwealth Fund is working to synthesize these multiple reports to see what they agree on. An initial review indicates that these reports do share many ideas. Among them:

- *Provider payment reform.* There seems to be general agreement to repeal Medicare's sustainable growth formula, to move from paying for volume (fee for service) to paying for value, and to enhance support for primary care.
- *Delivery system reform.* There is agreement to tie payment reform to improvements in the health care delivery system and to encourage the development and implementation of innovative delivery models.
- *Medicare reform.* There is agreement on the goal of improving the financial protection for beneficiaries (e.g. via catastrophic plans) and providing incentives for choosing value through high-performing providers.
- *Consumer/patient engagement.* There is agreement on the overall importance of engaging patients to be more active participants in their health care choices.
- *Enhancing performance of health care markets*. This will occur by increasing transparency of quality and cost information, and eliminating administrative inefficiency.

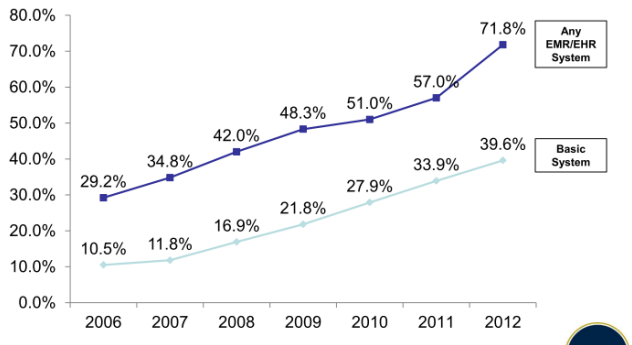
> *"There is an emerging consensus in both parties about directions we should go in."*
> — David Blumenthal

- **Adoption of HIT is proceeding rapidly.**

Already, 50% of eligible providers and 80% of hospitals have received payments for meaningful use of electronic health records, which is the level of adoption that CBO predicted would be obtained in 2019. The charts below show the rapid increases in the adoption of EHRs over the past few years.

15

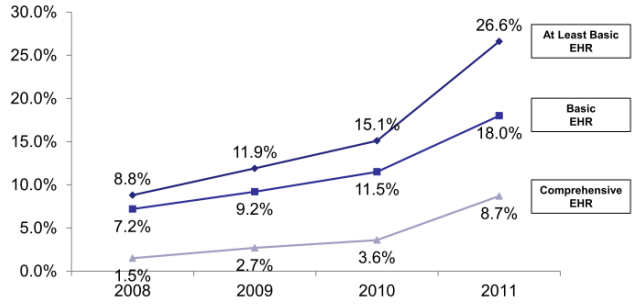
EHR Adoption Among Office-Based Physician Practices, 2006-12



Source: Hsiao CJ, Hing E. Use and characteristics of electronic health record systems among office-based physician practices: United States, 2001–2012. NCHS data brief, no 111. Hyattsville, MD: National Center for Health Statistics. 2012.

16

EHR Adoption Among Hospitals, 2008-11



Source: DesRoches CM, et al. Small, non-teaching, and rural hospitals continue to be slow in adopting electronic health record systems. Health Affairs, 2012.

Participant Discussion

- **Choice vs. systems.** In response to a question about two conflicting paradigms—a paradigm of choice or a paradigm of systems, where patients are locked into a particular system—Dr. Blumenthal argued that we can't go one road or the other. The public resists being locked in. To take advantage of the benefits of systems, we will have to work on the provider side to make it difficult for patients to not be part of systems. An alternative is reference pricing.
- **Exchange of information.** Adoption of EHRs and HIT has value, but not as much value as the exchange of information. Adoption is among individual entities (physicians or hospitals), while exchange is a team sport. The issue with information exchange is not a technical problem; it is that it is not in the interests of many participants to exchange information. It costs money, takes time and resources, and gives away proprietary information. Progress needs to be made to further improve the technology and to create a demand for information exchange.

Session VI: State Efforts to Control Total Health Care Costs

- Presenters: **Michael Bonetto, PhD, MPH, MS**, *Health Policy Advisor to the Governor, State of Oregon*
  Dan Crippen, PhD, *Executive Director, National Governors Association*
  Heather Howard, JD, *Director, State Quality and Value Strategies*
  Anya Rader Wallack, PhD, *Chair, Green Mountain Care Board*
- Moderator: **Len Nichols, PhD**, *Director, Center for Health Policy Research and Ethics, College of Health and Human Services, George Mason University*

Overview

States have tremendous latitude and authority to try to control costs through regulations and changes in payment systems, which can drive delivery system reforms. These changes include Medicaid, but are broader, affecting private insurance and the supply of and demand for health care services. States are laboratories of innovation, reflected by initiatives and pilots in many states aimed at improving outcomes and decreasing costs.

Mentioned repeatedly throughout this session were the political challenges that exist at the state level. States that have had success have had strong leadership of the governor and have achieved bipartisan, multi-stakeholder support.

Context

Presenters talked in general about the innovative role that states play in taking actions to control costs, and individuals from Vermont, Oregon, and Massachusetts then discussed what is happening in their states.

Key Takeaways

- **States are hotbeds of innovation in payment and delivery model reform.**

  In setting the context for this session, Len Nichols described how a wide variety of delivery and payment model innovations are springing up in numerous states. He laid out a hypothesis for innovation at the state level: *New service delivery and payment models will be more effective and produce better outcomes when they are implemented as part of a broad-based, governor-led, statewide initiative that brings together multiple payers and stakeholders—and uses the levers of state government to effect change*. Under this hypothesis, states can be strong partners in transforming health care because they:

  — *Pay for a large percentage of health care services.*

  — *Have broad regulatory powers over health care providers and payers.*

  — *Regulate public health, social service, and educational services.*

  — *Can convene multiple parties.*

  — *Are closer to the actual delivery of care.*

  — *Can integrate state health information exchange infrastructure and capabilities to support accountable care.*

> *"States are closer to the reality and they're doing lots of fascinating things . . . there is a tremendous groundswell of activities."*
> — Len Nichols

To illustrate his point about exciting activities taking place at the state level, Dr. Nichols summarized what is happening in Virginia. In 2010 the Virginia Health Innovation Center was created, based on the recommendation of the Virginia Health Reform Advisory Council. It is housed at the state Chamber of Commerce, signaling that employers are behind this. Multiple stakeholders have put up seed money. In a survey of hospitals and physician groups, there are over 400 examples of "triple aim seeking activities," almost none of which involve federal funding; they are led by private actors in cooperation with the state.

- **Vermont is aiming to control costs through regulation and innovation.**

  Health care spending is a problem in Vermont as it represents nearly 20% of the state's GDP, and per capita spending is 22% higher than in California. Contributing factors include having a lower rate of uninsured individuals and more generous coverage.

  In 2011, Vermont created the five-member Green Mountain Care Board that is charged with reviewing and regulating hospital budgets, health insurer rates, major capital expenditures, payment policies and rates, and certificates of need. This board has conducted payment analysis to understand variation. With one large network in the state (essentially a monopolistic provider market) and a concentrated insurer market, the Board sees its role as being a strong regulator. Decisions include allowing hospital budgets to grow by 3% and allowing investments of 1%.

> *"We have to figure out the right balance between what is really a monopolistic provider market and a very concentrated insurer market, and some kind of explicit constraints for our regulatory system."*
> — Anya Rader Wallack

On the innovation front the Board is responsible for payment reform pilots, six of which are under way, and the Board has the authority to create a "unified health care budget," which is still conceptual at this point. The state has received a $45 million Innovation Model Grant, which it is using to create a high-performance health system. There are three priorities: advancing payment reforms, creating an integrated health information system, and transforming the delivery system.

The governor wants to get to a single payer system, but the regulations and innovations taking place are necessary prerequisites to control costs before getting to such a system.

- **Oregon is attempting to address health care costs by changing how care is delivered, with broad political support.**

When Governor Kitzhaber was originally elected, Oregon faced a $3.5 billion budget deficit. Historically states balance budgets by cutting people from care, cutting rates, and/or cutting services. But with all of the stakeholders in Oregon agreeing that "we've got to change the health care business model, before it's too late," Oregon has taken a different approach. The idea is to create fiscal sustainability by changing how care is delivered. Goals are to improve health, reduce waste, align financial incentives, and create more local accountability.

Proceeding down this path started with a vision from the governor; it was a public process, and involved securing strong bipartisan support. With a House of Representatives split evenly with 30 Democrats and 30 Republicans, the two big health reform bills had House votes of 59-1 and 53-7.

> *"I can't emphasize enough the bipartisan support. . . . If I'm sitting down with a Republican or Democrat, it doesn't matter. Our message is how we are going to get better value for our health care dollar and how we are going to improve outcomes and get on a sustainable fiscal path."*
> — Mike Bonetto

Key elements of Oregon's plan to change care delivery included:

— *Securing a federal waiver.* Oregon secured a $1.9 billion federal waiver, which was an upfront investment over a five-year period. This waiver came in exchange for a commitment from Oregon to lower per capita spending by 2%.

— *Creation of coordinated care organizations (CCOs).* Oregon certified and launched a network of 15 CCOs, which coordinate care across the entire continuum, giving them an even greater scope than ACOs. More than 90% of the Medicaid population is enrolled in a CCO.

— *Establishment of metrics.* These include measures of quality, utilization, and costs, with baseline data and benchmarks. In total there are 33 metrics.

Overall, this plan focuses on delivering value, providing local flexibility with high levels of accountability, having one global budget that grows at a fixed rate, and achieving care coordination. Important lessons include the necessity of having strong leadership from the governor; having a public, transparent process; having bipartisan support and support from the business community; and including all stakeholders.

- **In reforming health care and controlling costs, Massachusetts is focused on more than just Medicaid.**

Stuart Altman said that while Medicaid is incredibly important, there is more in the health care system than just Medicaid, a fact that many states forget and overlook. (In many ways the federal government also has a limited world view, believing that the world begins and ends with Medicare.) In fact, what is going on in the private sector (with insurers and providers) is also extremely important. For example, tiered networks are taking off, as are high deductible health plans.

> *"We cannot talk about a health care system by just focusing on Medicaid and Medicare. It needs to be a full system. . . . States have a lot of responsibilities; they have a lot of authority."*
> — Stuart Altman

Massachusetts realizes that major changes are taking place in the private sector, and the state has recognized the need to focus more broadly than just on Medicare and Medicaid. Through several pieces of legislation Massachusetts is attempting to contain costs.

One specific component of legislation passed in August 2012 is creation of the Health Policy Commission, an 11-member board chaired by Professor Altman. This Commission is not a regulator, but is charged with overseeing all aspects of health care reform in Massachusetts. This includes conducting analysis and weighing in on the appropriateness of legislative targets and spending relative to these targets, as well as the performance of individual providers, including corrective action plans and penalties for providers who fail to reform the system; providers who use their market power to raise rates will be referred to the Attorney General. The Commission certifies ACOs and PCMHs, assists in the review of risk-based provider organizations, and establishes patient protections and quality oversight. The Commission is also developing an all-claims database that will be a tremendous resource.

> *"We [the Commission] are really there to assist the marketplace."*
> — Stuart Altman

- **In all states there are steps that can be taken to increase the supply of health services and decrease demand.**

Representing the National Governors Association, Dan Crippen addressed actions that states can take to improve the health of citizens by increasing the supply of care and related services, while simultaneously decreasing the demand for various services.

> *"The states have a lot of latitude . . . there are many things that states can do that can affect health care."*
> — Dan Crippen

Among the actions that states can take on their own:

— *Increasing supply.* There are 50 million children who didn't receive any dental care last year and 40 million people who live in areas with insufficient dental care. States now allow dental hygienists into prisons and nursing homes, but they are often not allowed to treat children or people lacking access to a dentist. State laws need to be revised in such areas to increase supply.

— *Decreasing demand*. Chronically ill patients and asthmatic kids are two groups for whom it is possible to perform focused

interventions and decrease their utilization of services. Also, it is possible to reduce the utilization of hospitals and nursing homes by changing incentives and increasing price transparency.

— *Taking advantage of states' position as major purchasers.* States are huge purchasers of health care services but often fail to leverage this purchasing clout.

— *Communication.* States can be involved in communication activities such as reminding patients of appointments and to refill prescriptions. Communication of various physical and mental health activities can be combined at the state level.

— *Regulation* of insurers and providers. States also grant licenses and deal with the scope of practice.

— *Revising malpractice laws,* which contribute to high costs.

— *Dealing with antitrust issues*, which is of growing importance as more mergers and acquisitions occur.

— *Medical education.* States often run schools for various medical professionals. In doing so, states can decide on the number of people in various professions to educate (i.e. the number of nurses or dental hygienists) and the curriculum.

— *Public health.* Even though public health departments play a critical role, less than 3% of health care spending is on public health and public health is often the first thing cut when budgets are tight. With issues like obesity and behavioral health, public health plays a key role.

- **The Robert Wood Johnson Foundation has two important programs that are providing technical assistance to states.**

> *"Two RWJF programs are helping states navigate this new world . . . helping states create successful models."*
> — Heather Howard

These two programs are:

1. *State Health Reform Assistance Network.* This program provides technical assistance to states to help them maximize their coverage expansion under ACA. The idea is to develop successful implementation models across a diverse group of 11 states and to share the lessons learned.
2. *State Quality and Value Strategies.* This program provides technical assistance to help states build on quality and value initiatives. RWJF is helping states:
   - *Shape incentives via reforms in payment and purchasing.*
   - *Gather, share, and use data to promote quality and value.*
   - *Engage stakeholders inside and outside of government.*

   States are using numerous approaches to improve quality including multi-payer coalitions, ACOs and PCMHs, initiatives focused on dual eligibles, and efforts to reform data collection and quality metrics.

Some of the reforms taking place at the state level would have taken place regardless of the ACA. This includes efforts in Alabama to create regional care organizations and in New Mexico to reform the delivery system with emphasis on pay-for-performance and personal responsibility.

Other states used the ACA as a catalyst to pursue reforms, including Colorado where the Medicaid expansion under the ACA was the impetus for broad reforms. States are also using the ACA Exchanges as a venue to provide transparency to improve quality and value.

Participant Discussion

- **Opportunity in Massachusetts.** One participant suggested that the Commission in Massachusetts not get distracted by relatively trivial administrative matters but use this opportunity to create a vision for how the health system should actually work. (Stuart Altman agreed.)

> *"The changes that are going to take place—whether they are good or bad, or whether they work or not—are going to be done much more at the state level than the federal level."*
> — Stuart Altman

Session VII: Medicaid 2020

- Presenters: **Greg Moody, MA**, *Director, Governor's Office of Health Transformation, State of Ohio*
  David Sundwall, MD, *Professor of Public Health, University of Utah School of Medicine*
  Steven Wray, MS, *Executive Director, Economy League of Greater Philadelphia*
- Moderator: **Trish Riley, MS**, *Visiting Fellow and Lecturer in State Health Policy, George Washington University*

Overview

It is an extremely important time for Medicaid. States have to decide whether to expand Medicaid, and regardless of their decision, must streamline and modernize Medicaid. Considerations are moral, political, financial and economic, and practical.

Context

After Trish Riley provided an overview of changes affecting Medicaid, the other panelists described how their states—Utah, Pennsylvania, and Ohio—are thinking about Medicaid expansion.

Key Takeaways

- **It is an extremely important time for Medicaid.**

  Already, Medicaid is bigger than Medicare by about seven million members, and this is likely to increase significantly, depending on states' decisions about expanding Medicaid. Regardless of whether a state expands Medicaid, there are some fundamental changes that must be made, including eligibility changes, as eligibility must be simplified and streamlined, and Medicaid must be coordinated with exchanges.

  > *"States have to fundamentally redesign and modernize the Medicaid program."*
  > — Trish Riley

  In reality, there are now essentially two different Medicaid programs. The first is the old Medicaid program, for long-term care and for people with disabilities. The second Medicaid program is health insurance for low-income people, which has been de-linked from welfare.

  Those who support expansion see it as a moral imperative, an equity issue, and a good deal for states since the federal government is footing the entire bill for the first three years and phasing to 90% payment after that. Currently, 28 governors support expansion.

  At the same time, 20 governors oppose expansion (with the rest having not yet committed). Those who oppose expansion have ideological concerns about the role of state governments in providing insurance, believe Medicaid is broken and see it as a weak foundation to build on, and have financial concerns in that even paying for 10% of the expansion is significant. They also worry about administrative complexity.

  The political issues go beyond the views of the governors in that expansion must be approved by the state legislature. In some states the governor supports expansion but the legislature opposes it. Increasingly state legislatures are as polarized as Congress. The elections in 2014 will be critical as Congress and legislatures are up for reelection, and 38 states will elect governors.

- **Utah has a good safety net, but there is a good chance that after much consideration, it will decide to expand Medicaid.**

  Utah, which already has a decent safety net (with almost 50 clinics serving the poor), is working on payment reform, workforce issues (which don't get enough attention), and health information technology, where the state has been a leader. Utah's health system reform efforts have responded to the state's unique business and demographic needs, and its approach is to rely on the invisible hand of the marketplace, rather than the heavy hand of government.

  In considering whether to expand Medicaid, Utah has looked at a broad range of scenarios. Analysis shows that expansion would add about 110,000 people to Medicaid with an annual budget increase of $584 million.

  It is Professor Sundwall's prognosis, knowing the people and climate in Utah, that after wresting with the topic, complaining about it, and imagining dire consequences, Utah's pragmatic leaders will ultimately decide to expand Medicaid in some way.

  Professor Sundwall made clear that those in Utah who do not favor expanding Medicaid are not immoral. They may support improving care for the poor but have misgivings about the long-term costs, about whether the federal government will be able to afford footing the entire bill for three years and then 90% thereafter, about the complexity of regulations, and about expanding the role of the federal government. Also, many in Utah feel it is immoral to increase federal spending, thus contributing to the country's debt and deficits.

  Personally, Professor Sundwall favors expanding insurance coverage, but believes that the ACA legislation "picked the wrong horse to ride with Medicaid." He sees Medicaid as too costly and believes its current structure as a federal/state partnership is too complex. His opinion is that Medicaid should be federalized and merged with Medicare.

- **Looking at the expansion of Medicaid from an economic analysis perspective shows a net benefit to Pennsylvania.**

  Steven Wray described how the Economy League of Greater Philadelphia conducts non-partisan economic impact studies. This organization completed an analysis to understand the economic and fiscal impact of expanding Medicaid in Pennsylvania. Important elements of this analysis include:

  — Expansion would increase Medicaid coverage by 542,000 individuals by 2016, 313,000 of whom are currently uninsured.

  — The federal share of costs would be $3.8 billion in 2016 and $5.5 billion in 2022. Pennsylvania's share would be $29 million in 2016 and $645 million in 2022.

— Expansion would lower state-funded health care costs by $412 million in 2016, by $595 million in 2022, and by a cumulative $4.4 billion from 2013 to 2022.

— Federal funds would generate new spending in Pennsylvania. This includes new household spending of more than $12 billion and new health care spending of $18 billion from 2013 to 2022. This new spending would lead to more than 42,000 new jobs in 2022 and $4.4 billion in GDP. This translates to a 1% boost to the state's economy. Wages and earnings would also grow.

— The economic expansion from Medicaid would generate about $3.6 billion in increased state tax revenue from 2013 to 2022.

— The net fiscal impact is positive. The combination of budget savings and new revenue will create a positive impact of more than $5 billion for Pennsylvania.

This economic impact study produced results and conclusions similar to three other studies. They all showed hundreds of thousands of people getting coverage, with billions of dollars in federal and state spending. The overall economic impact is positive, as is the overall fiscal impact for Pennsylvania. Still, as the federal match declines, the spending by the state will increase, which is a source of concern. This analysis, along with the others, is an input into Pennsylvania's political decision.

- **Ohio has developed and is executing a plan to transform its health system and to modernize Medicaid.**

As of 2011, Ohio had a $7.7 billion fiscal imbalance, Medicaid spending represented about one third of the state budget and had increased by 33% over the three prior years, and Medicaid over-spending required multiple budget corrections.

> *"Ohio Medicaid was stuck in the past and in need of reform . . . when we looked at this, we couldn't do something incremental. We had to do something pretty big."*
> — Greg Moody

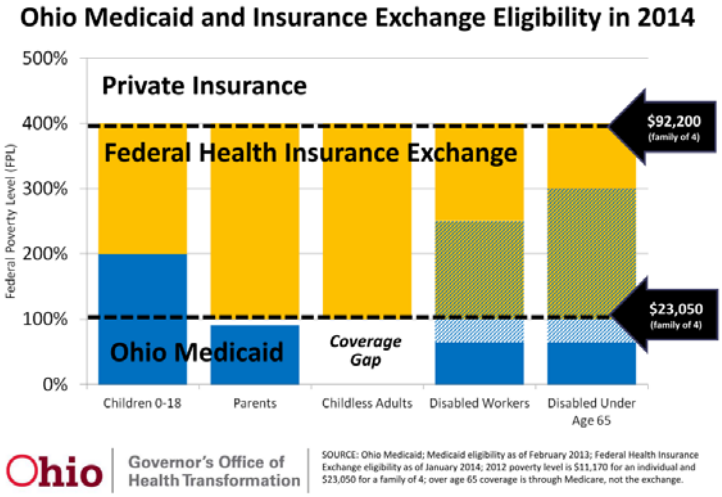
So, on Governor John Kasich's third day in office, he created the Office of Health Transformation which took the state's health and human services agencies and organized them under a single point of control for strategic planning and budgeting. On his fourth day, an application to be a dual-eligible demonstration state was submitted. And on the fifth day, a comprehensive health transformation plan was approved to improve overall health system performance.

The first priority in the state's transformation plan (shown in the next slide) was to modernize Medicaid to contribute to stabilizing the state's budget. The plan called for then investing in some infrastructure and proceeding to treat Medicaid like other items that the state purchased, and buying based on value. No part of this plan was original; all aspects were borrowed or copied from elsewhere.

Ohio Health Transformation Plan

Modernize Medicaid	Streamline Health and Human Services	Pay for Value
Initiate in 2011	*Initiate in 2012*	*Initiate in 2013*
Medicaid Cabinet: OHT (sponsor); AGE, ODH, ADA, MH, DD, Medicaid; with connections to JFS	**HHS Cabinet:** DAS, OBM, OHT (sponsors); JFS, RSC, AGE, ADA, MH, DD, ODH, Medicaid; with connections to ODE, DRC, DYS, DVS, ODI, TAX	**Payment Innovation Task Force:** OHT (sponsor); Medicaid, BWC, DAS, DEV, DRC, JobsOhio, OPERS, ODI, TAX
• Eliminate fraud and abuse • Prioritize home and community services • Reform nursing facility payment • Enhance community DD services • Integrate Medicare and Medicaid benefits • Rebuild community behavioral health system capacity • Create health homes for people with mental illness • Restructure behavioral health system financing • Improve Medicaid managed care plan performance • Extend Medicaid coverage to more low-income Ohioans	• Create the Office of Health Transformation (2011) • Implement a new Medicaid claims payment system (2011) • Create a unified Medicaid budget, accounting system • Create a cabinet-level Medicaid Department (July 2013) • Consolidate mental health and addiction services (July 2013) • Simplify and replace Ohio's 34-year-old eligibility system • Coordinate workforce programs • Share services across local jurisdictions • Recommend a permanent HHS structure (coming soon)	• Participate in Catalyst for Payment Reform • Provide access to medical homes for most Ohioans • Use episode-based payments for acute medical events • Pioneer accountable care organizations • Accelerate electronic health information exchange • Promote insurance market competition and affordability • Support regional payment innovation

In developing plans to modernize Medicaid, an obvious gap in the state's program was a coverage gap for childless adults and some parents who fell below 100% of poverty. These individuals, at the lowest income levels, many of whom were working, received no assistance whatsoever. (Ironically, many of the people affected by this coverage gap worked in health care.) Addressing this gap is an issue of justice.



The biggest challenge in Ohio has been political. Even though Governor Kasich supports expanding Medicaid and dealing with the coverage gap, the legislature won't support it. Even though legislators acknowledge that certain policies are the right thing to do, they won't support them for political reasons.

> *"Don't bother me with the policy, because I already have a viewpoint."*
> — Greg Moody, describing the attitude of many legislators

The stakeholders in Ohio have now initiated a process of putting Medicaid expansion on the ballot to have it voted on by the state.

Despite these political challenges, there has been success in Ohio. There is now a balanced budget and Medicaid growth in 2012 was below 3%; it came in $590 million under budget. And, Ohio has emerged as a leader in efforts to modernize Medicaid. However, as was the case in 2011, there are still 1.5 million Ohioans who lack insurance, a problem that must be addressed.

Participant Discussion

- **Qualification standards.** States treat different populations differently, with parents treated differently from children and someone at 100% of poverty treated differently from someone at 200% of poverty. For parents, the median income eligibility standard among the 50 states is 63% of poverty. For a family of four, this is income of less than $15,000—in 43 states, these individuals wouldn't qualify for anything. A person can be penniless and ineligible for Medicaid.

Session VIII: The Private Insurance Market and Health Care Exchanges

- Presenters: **David Abernethy**, *Senior Vice President, Government Relations, EmblemHealth*
  Jon Kingsdale, PhD, *Managing Director, Wakely Consulting Group*
  Sandy Praeger, *Insurance Commissioner, State of Kansas, Chair of NAIC Health and Managed Care Committee*
- Moderator: **Susan Dentzer**, *Senior Policy Advisor, Robert Wood Jonson Foundation*

Overview

While large employers are likely to continue providing group coverage for their employees, and while health plans will continue to focus on this market, health insurance exchanges will change how business is conducted for the small group and individual markets that will represent about 9% of the total insurance market. The theory is that through the competition on exchanges, rates and administrative costs can be reduced. But there are numerous regulations and operational hurdles that must be addressed, and public awareness remains low. States are "sprinting to the starting line," hoping to have basic services in place by October 2013.

Among the many unknowns and concerns, perhaps most significant is the reaction of politicians, the media, and the public as rates for some individuals and small businesses go up dramatically.

Context

The presenters described preparing for, implementing, and the impact of health care insurance exchanges, as well as the impact of ACA on the private insurance market. David Abernethy provided the perspective of an insurance plan.

Key Takeaways

- **The health insurance exchanges that will commence in the fall of 2013 are the result of a lengthy evolution.**

  The evolution of insurance exchanges began in the 1980s with the theory of managed competition. The idea was that by creating large groups ("purchasing cooperatives"), risk could be spread, making insurance more affordable for individuals and small groups. This evolved into regional health "alliances" in the Clinton Health Plan of the 1990s, followed by health insurance exchanges in ACA. The idea was for state-based exchanges, with a single federal exchange as a fallback option if a state didn't want its own exchange. That has evolved into "marketplaces," which can be state-based, partnerships, or federally facilitated.

The theory behind exchanges had the following elements:

— Exchanges and insurance reform together would dramatically improve coverage in the non-group (individual) and small group markets.

— Coverage options would be standardized, making it easier for consumers to comparison shop for price, cost sharing, networks, and aspects of coverage that go beyond the essential benefits package.

— Premiums would be subsidized according to the federal poverty level, bringing more people into the exchanges.

— Administrative costs for individuals and small employers would be reduced and plans would be able to negotiate better prices with providers.

> *"The whole construct is really designed to make competition come to life in the insurance market."*
> — Susan Dentzer

- **Actually implementing exchanges requires dealing with a host of design decisions and operational issues.**

  While still in flux, it appears that 17 states and the District of Columbia will run their own exchange, 7 states have been conditionally approved for partnership exchanges, and all other states will default to the federal facilitated exchange.

  Regarding the products sold, states are required to offer a variety of certified health plans that meet the state's version of "essential health benefits." (Since essential benefits are being decided at the state level, there will be 50 different essential benefits packages.) There will also be two multi-state plans for sale in each state. Some states are following an "active purchasing model" and other states have more of a "clearinghouse model." Also, exchanges have to serve as enrollment portals for Medicaid and CHIP. (A question at the moment is how many states will be able to make real-time determinations of eligibility.)

  While many operational uncertainties still remain, also uncertain is how exchanges will affect premiums. In many respects premium levels will reflect how competitive or non-competitive the insurance markets are and how dominant the provider systems are. On top of this is low public awareness about exchanges and what they are supposed to do.

> *"How much does the public understand about any of this? Almost nothing."*
> — Susan Dentzer

- **2014 is just the beginning of health reform, not the end.**

  Drawing on the experience in Massachusetts, Jon Kingsdale described what is currently occurring as "a race to the starting blocks." He said reform will happen over five years or more, and reform will be followed by more reform.

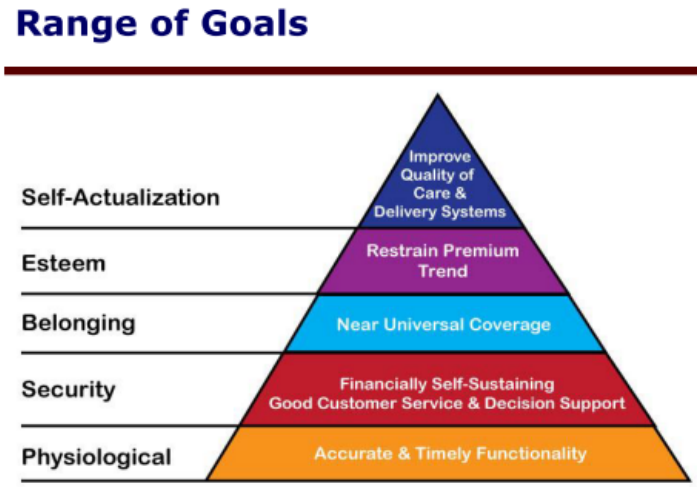
Dr. Kingsdale observed that half the states in the country contain costs by letting the number of uninsured grow. Once many of these individuals are insured, states will have to confront that costs are unsustainable. He also observed that setting up exchanges and controlling costs is so hard because:

— *It is completely new*. State governments have never created marketplaces and don't know how to engage in retail marketing.

— *The politics are excruciating*. Some states vehemently oppose ACA and exchanges and want them to fail, and even in states where politicians support the concept, there are still political messes.

— *Congress provided too much time*. Congress gave states three and a half years. This long timing was to delay the budgetary impact.

Dr. Kingsdale compared the implementation of exchanges to Maslow's hierarchy of needs. Just as humans focus first on their most basic needs, states are focusing first on the basics, such as accurate and timely functionality. Then, over the longer term, they will tackle goals like creating exchanges that are financially self-sustaining with good service and decision support; having near universal coverage; controlling premium costs; and improving the quality of care and delivery systems. While the media will cover the first day that the exchanges open, real data will probably start coming in by 2016.



> *"In October 2013, they're just looking to meet basic needs. If they can provide timely, accurate functionality and information, that would be a huge success."*
> — Jon Kingsdale

Dr. Kingsdale is most worried about the unknowns. He gave an example of a small business that will have its insurance rates go up by 42%, which is an unintended consequence of imposing a national rating system on local markets. While some businesses will have their rates fall significantly (and will be silent), those that have their rates rise will be angry and loud.

- **Kansas is taking many important steps, even though it is not implementing an exchange.**

Kansas, a red state, has abdicated its responsibility to run an exchange to the federal government because the state's leaders don't want to help the ACA succeed, and would actually like it to be repealed.

Even though Kansas will have a federally facilitated exchange, there are still several important steps taking place at the state level. This includes plan management, eligibility, enrollment, financing, and consumer assistance.

As Kansas prepares to implement ACA—which includes guaranteed issue, adjusted community ratings and more—Sandy Praeger's biggest concern is adverse selection. She is also worried about creating consumer awareness, as Kansas is receiving just $600,000 for outreach.

To try to mitigate rate increases, Kansas is looking at strategies such as reinsurance, risk corridors, risk adjustment, medical loss ratio, transparency, and more. Also, Kansas believes it has enough authority to approve rates for companies that want to be listed on the exchange.

> *"The ultimate weapon that that federal exchange has, they can deny access to the exchange for a company whose rates are viewed as excessive, even though they don't have rate approval authority in the federal law."*
> — Sandy Praeger

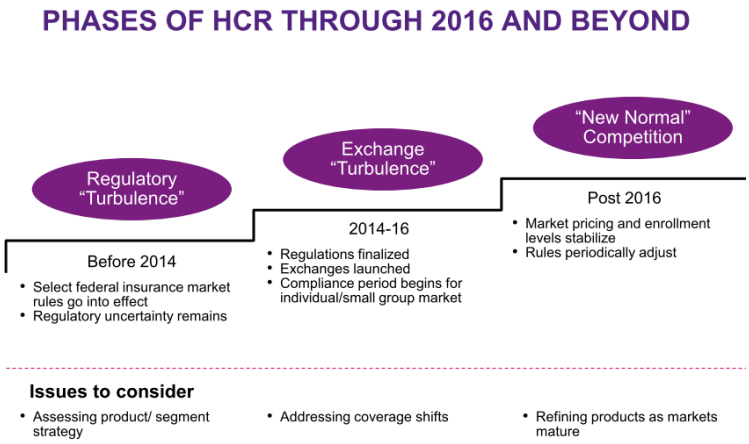
- **From the perspective of a major health insurer, the primary focus remains the large employer market.**

David Abernethy offered the perspective of EmblemHealth, a New York-based health insurance plan. He reminded everyone that 150 million people are currently in group health insurance plans, and said those individuals will largely be unaffected by ACA and by state health care exchanges, other than a 3% tax that will be absorbed by employers. He said the individual and small group markets have not been important businesses for health plans because it has always been hard to make money in these markets. (Ms. Dentzer said that if exchanges go as expected, they will represent just 9%, at most, of the U.S. health insurance market.) Most health plans will continue to focus on the employer group market and on the Medicare and Medicaid markets, where money can be made.

> *"A dirty little secret: the individual and small group market is not our business for the most part. It's a bit of a side show. It's very difficult, and always has been, to make much money at it."*
> — David Abernethy

In looking at health care reform, EmblemHealth sees three phases: before 2014 will be a period of "regulatory turbulence" as the rules are established. From 2014 to 2016 will be a period of "exchange turbulence" as regulations are finalized, exchanges

are launched, and insurers must comply. After 2016, a "new normal" for competition will take hold.



EmblemHealth has decided to participate only in New York's individual exchange, but not the small group exchange, because the small group market has generally not been profitable in New York and cost-sharing subsidies are only available for the individual market, not the small group market. Also, EmblemHealth believes that many small employers will drop their coverage and send their employees to the individual exchange, and the small group risk pool is likely to deteriorate.

EmblemHealth is presently working to do what is required to be in compliance with the law, and to get ready to participate in New York's state health exchange.

That involves a host of actions including:

— Covering preventive services.
— Establishing a minimum medical loss ratio.
— Having a uniform summary of benefits.
— Establishing deductible limits.
— Ensuring that, at a minimum, plans have the essential health benefits.
— Eliminating annual and lifetime dollar limits and pre-existing condition exclusions.
— Guaranteeing coverage to eligible employees with a 90-day waiting period.
— Providing guaranteed issue and renewability.
— Implementing community rating.

EmblemHealth and other New York plans already comply with many of these requirements, as similar or even more stringent requirements have already existed in New York.

In addition to compliance, EmblemHealth has adopted a strategy to identify and target specific neighborhoods ("micro-marketing") in the New York City area that offer opportunities for membership growth and retention. EmblemHealth is also opening Neighborhood Health Centers that offer social and disease-related service in strategic neighborhoods.

Participant Discussion

- **Part D analog.** With Medicare Part D, everything that was predicted turned out to be wrong, and everything that went wrong was not predicted. How, it should be noted that while many analysts predicted that no companies would offer Part D plans, there are more than 8,000 plans.
- **Managed care analog.** Stuart Altman said that the vast majority of the population had no problem with managed care. But the small minority who did have a problem—along with the sensationalistic media—managed to blow it up. With 50% of the population opposing ACA, the media will find every little problem and will blow it up. This game isn't over. The people whose voices will matter most are not the uninsured; it is the people who vote and who have power.
- **Blame it on exchanges?** With public ignorance being so high, if individuals or small businesses see their rates go up, they may blame this on exchanges, as opposed to insurance reform.
- **Movement of rates.** It has been reported that small group rates in California will go down 28% and rates for some groups, such as middle-aged women, may decline. But rates for other groups will increase.
- **Concentration of uninsured.** One participant pointed out that of the country's 3,033 counties, over half of the uninsured are in 114 of them, which is less than 4%. About 160 counties account for two thirds of the uninsured. This would indicate the need for targeted programs.
- **Outreach funding.** While Kansas is getting $600,000 for outreach, Maryland is getting $45 million and Connecticut is receiving $17 million.
- **Outreach activities.** Outreach will take multiple forms, including social media, peer-to-peer marketing, and activities targeting women and asking them to communicate with their children and with nephews and nieces to stress the importance of having insurance.

Biographies

David Abernethy
Senior Vice President, Government Relations, EmblemHealth

David S. Abernethy is Senior Vice President, Government Relations, of EmblemHealth, the parent company of HIP Health Plan of New York, Group Health Incorporated, and ConnectiCare. He is responsible for all issues relating to Federal and State government relations for the health plans and for directing the company's Washington office. He has been with EmblemHealth and with HIP in various executive positions since January 1996.

Prior to joining EmblemHealth, Mr. Abernethy worked from 1987 to 1996 for the Committee on Ways and Means of the U.S. House of Representatives in a variety of positions including Staff Director of the Subcommittee on Health. As such he was the Committee's principal staff person for Medicare and for health reform. He was particularly involved in the design of legislation concerning comprehensive health insurance, hospital payment policy, managed care, tax treatment of health care organizations, reorganization of rural health care, and related topics.

Prior to joining the Committee on Ways and Means, Mr. Abernethy was Deputy Commissioner of Health for Planning, Policy, and Resource Development for the New York State Department of Health. In that capacity, from 1982 through 1987, he directed the Department's planning and policy development division, developing a range of initiatives affecting long-term care financing, hospital reimbursement and capital investment, ambulatory surgery, primary care in underserved areas, maternal and child health, and preventive health services in the State of New York. Mr. Abernethy directed the State's health planning and development activities and coordinated the Department's federal affairs.

Mr. Abernethy is the author with David A. Pearson of *Regulating Hospital Costs: The Development of Public Policy* as well as a number of articles on health policy. He is the former President of the American Health Planning Association (AHPA) and a recipient of the Richard H. Schlesinger Achievement Award given by AHPA and the American Public Health Association (APHA). He is formerly a member of the Governing Council of APHA. He has held teaching positions in health policy at the School of Hygiene and Public Health of the Johns Hopkins University and the School of Public Health of the University of North Carolina at Chapel Hill.

Mr. Abernethy has also worked for the Subcommittee on Health and the Environment of the House Committee on Commerce (1977-1980) and as the Administrator of the Haight-Ashbury Free Medical Clinic in San Francisco (1974-1976). He holds a Master's degree in Public Health (Health Services Administration) from Yale University and a Bachelor of Arts degree from Claremont Men's College, cum laude in History.

Mr. Abernethy is married to Elizabeth Parker Lewis and has two children, Janie and Thomas.

Stuart Altman, PhD
Sol C. Chaikin Professor of National Health Policy, Brandeis University

Dr. Stuart Altman, Sol C. Chaikin Professor of National Health Policy at The Heller School for Social Policy and Management, Brandeis University, is an economist with approximately five decades of experience working closely with issues of federal and state health policy within government, the private sector, and academia. He has demonstrated leadership in health care through service on numerous government advisory boards on both the federal and state levels, including service as the Deputy Assistant Secretary for Planning and Evaluation/Health at the U.S. Department of Health Education and Welfare (HEW) from 1971 to 1976; as Chairman of the Prospective Payment Assessment Commission (ProPac) from 1984 to 1996; and in 1997 as an appointed member of the National Bipartisan Commission on the Future of Medicare. In total, Dr. Altman acted as advisor to five U.S. presidential administrations. In November 2012, Governor Deval Patrick appointed Dr. Altman to chair the board of the Health Policy Commission as part of Massachusetts' implementation of a health care cost containment law passed earlier that year.

Dr. Altman has also been recognized as a leader in the health care field by *Health Affairs* and by *Modern Healthcare*, which named him in 2006 among the 30 most influential people in health policy over the previous 30 years, and which from 2003 to 2011 named him one of the top 100 most powerful people in health care. He has served on the Board of Directors of several for-profit and not-for-profit companies, and he is a member of The Institute of Medicine and chairs the Health Industry Forum at Brandeis University. He is a published author of numerous books and journal articles, the most recent, *Power, Politics and Universal Health Care: The Inside Story of a Century-Long Battle* (2011). In addition to teaching at Brandeis, Dr. Altman has taught at Brown University and at the Graduate School of Public Policy at the University of California at Berkeley. He served as Dean of the Heller School from 1977 to 1993 and from 2005 to 2008. He also served as interim President of Brandeis University from 1990 to 1991.

Kristine Martin Anderson, MBA
Senior Vice President, Booz Allen Hamilton

Kristine Martin Anderson is a Booz Allen Hamilton Senior Vice President aligned to the health care sector. She is recognized as a thought leader for her expertise in health information technology, health information exchange and evaluating and improving clinical quality of care. She focuses on the use of HIT and incentives to transform performance measurement and improvement. Prior to joining Booz Allen, she was a founding employee at CareScience, a software solutions company that she helped to launch in 1992 and take public in 2000. CareScience launched the nation's first Web-based clinical decision support system for hospitals, and the nation's first HIE.

Joseph Antos, PhD
Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute

Joseph Antos is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, a nonpartisan public policy organization based in Washington, DC. He is also a member of the Panel of Health Advisers for the Congressional Budget Office. He recently completed two terms as a commissioner of the Maryland Health Services Cost Review Commission, which regulates payment rates and oversees the financial performance of all hospitals in the state. His research focuses on the economics of health policy, including Medicare and broader health system reform, health care financing and the budget, health insurance regulation, and the uninsured.

Prior to joining AEI, Mr. Antos was Assistant Director for Health and Human Resources at the Congressional Budget Office from 1995 to 2001. He held several senior management positions in the Healthcare Financing Administration (now called the Centers for Medicare and Medicaid Services), including Director of the Office of Research and Demonstrations from 1987 to 1993. He also was Principal Deputy Assistant Secretary for Management and Budget and Deputy Chief of Staff for the U.S. Department of Health and Human Services in 1986 and 1987. He also held senior positions in the Office of Management and Budget and the President's Council of Economic Advisers, from 1983 to 1986. Antos has a PhD in economics from the University of Rochester.

David Blumenthal, MD, MPP
President, The Commonwealth Fund

David Blumenthal, MD, MPP, is president of The Commonwealth Fund, a national philanthropy engaged in independent research on health and social policy issues.

Dr. Blumenthal is formerly the Samuel O. Thier Professor of Medicine at Harvard Medical School and Chief Health Information and Innovation Officer at Partners Healthcare System in Boston. He is also chairman of The Commonwealth Fund Commission on a High Performance Health System. From 2009 to 2011, he served as the National Coordinator for Health Information Technology, with the charge to build an interoperable, private, and secure nationwide health information system and to support the widespread, meaningful use of health IT. He succeeded in putting in place one of the largest publicly funded infrastructure investments the nation has ever made in such a short time period, in health care or any other field.

Previously, Dr. Blumenthal was a practicing primary care physician, director of the Institute for Health Policy, and professor of medicine and health policy at Massachusetts General Hospital/Partners Healthcare System and Harvard Medical School. He is the author of more than 250 books and scholarly publications, including most recently, *Heart of Power: Health and Politics in the Oval Office*. He is a member of the Institute of Medicine and a former board member and national correspondent for the *New England Journal of Medicine*. He has also served on the staff of the U.S. Senate Subcommittee on Health and Scientific Research; is the founding chairman of AcademyHealth, the national organization of health services researchers; and a trustee of the University of Pennsylvania Health System.
Dr. Blumenthal received his undergraduate, medical, and public policy degrees from Harvard University and completed his residency in internal medicine at Massachusetts General Hospital. With his colleagues from Harvard Medical School, he authored the seminal studies on the adoption and use of health information technology in the United States. He has held several leadership positions in medicine, government, and academia, including senior vice president at Boston's Brigham and Women's Hospital and executive director of the Center for Health Policy and Management and lecturer on public policy at the Kennedy School of Government. He served previously on the board of the University of Chicago Health System and is recipient of the Distinguished Investigator Award from AcademyHealth, an Honorary Doctor of Humane Letters from Rush University and an Honorary Doctor of Science from the State University of New York Downstate.

Michael Bonetto, PhD, MPH, MS
Health Policy Advisor to the Governor, State of Oregon

Mike Bonetto has a unique portfolio of health care policy and planning experience. He is currently the Health Policy Advisor to Governor Kitzhaber and has been the Vice President of Business and Community Development for St. Charles Health System; the Senior Vice President of Planning & Development for Clear Choice Health Plans; Director of the Oregon Health Policy Commission; Senior Policy Advisor to the Oregon Senate Republican Caucus; and Policy Analyst for the Oregon Insurance Pool Governing Board.

Mike received a PhD in health policy, Master of Public Health from Oregon State University, and Master of Science from California State University, Fullerton, and a Bachelor of Arts from Occidental College.

Mike's current activities include: President and Co-Founder, HealthMatters of Central Oregon; Board Member, Deschutes County Public Health Advisory Board; Board Member, Oregon Health Policy Board; Board Member, Mosaic Medical (Federally Qualified Health Center in Central Oregon).

Liora Bowers, MBA, MPH
Director of Health Policy and Practice, Berkeley Forum, UC Berkeley School of Public Health

Liora Bowers is the Director of Health Policy and Practice for the Berkeley Forum, a multi-stakeholder collaborative of CEOs of major health insurers, providers, and public sector leaders working to improve affordability and value in the California healthcare system. She is the co-lead author of the unprecedented Berkeley Forum report: *"A New Vision for California's Healthcare System,"* released in February 2013.

Liora has policy, strategy and marketing consulting experience with various healthcare organizations, including the Clinton Health Access Initiative Drug Access Team, the California Center for Connected Health Policy, LifeLong Medical Care and TrustMD. Additionally, she worked on a high-impact health reform strategy project for a large hospital system while at Deloitte Consulting and led competitive intelligence efforts at Onyx Pharmaceuticals for the launch of a multiple myeloma drug. Liora began her career in

Investment Banking, where she was heavily involved in over ten successful mergers & acquisitions, financings, and restructurings for a range of middle-market companies. Liora holds an MBA with honors from the Haas School of Business and an MPH from University of California, Berkeley. She graduated Phi Beta Kappa with a BS in International Economics from Georgetown University, where she played #1 singles on the women's Division I tennis team.

Stuart Butler, PhD
Distinguished Fellow and Director, Center for Policy Innovation, The Heritage Foundation

Stuart M. Butler is Director of the Center for Policy Innovation at The Heritage Foundation in Washington DC. The Center is Heritage's "think tank within a think tank" and focuses on developing new and breakthrough policy ideas. Prior to taking up this position in 2010 he served as Vice-President for Domestic and Economic Policy Studies, where he planned and oversaw the Foundation's research and publications on all domestic issues. He is an expert on health, welfare and Social Security policy. He is an Adjunct Professor at Georgetown University Graduate School and in 2002 he was a Fellow at Harvard University's Institute of Politics. He is also a member of the editorial board of *Health Affairs*, serves on the panel of health advisers for the Congressional Budget Office, and is a member of the Board on Health Care Services of the Institute of Medicine.

Dr Butler has authored books and articles on a wide range of issues. Among these is *Enterprise Zones: Greenlining the Inner Cities* (Universe Books), and *Privatizing Federal Spending* (Universe). His book, *Out of the Poverty Trap* (Free Press), co-authored with Anna Kondratas, laid out a comprehensive conservative "war on poverty." *A National Health System for America* (Heritage), co-authored with Edmund Haislmaier, laid out a blueprint for a national health system based on free market principles.

Dr Butler has played a prominent role in the debate over federal spending, health care, economic mobility, and entitlement reform, arguing for solutions based on limited government and market competition. But he is also widely recognized as an individual who is willing to work with people across the ideological spectrum to find solutions to the nation's problems. He has written extensively on many issues and has testified frequently before Congress on a broad range of issues.

Stuart Butler was born in Shrewsbury, England, in 1947 and emigrated to the U.S. in 1975. He became an American citizen in 1995. He was educated at St. Andrews University in Scotland, where he received a Bachelor of Science degree in physics and mathematics in 1968, a master's degree in economics and history in 1971, and a PhD in American economic history in 1978. He is married with two daughters, and resides in Washington DC.

Christine Cassel, MD
President and CEO, National Quality Forum

Christine K. Cassel, MD, President and CEO of the American Board of Internal Medicine (ABIM) and the ABIM Foundation, is an expert in geriatric medicine, medical ethics and quality of care. Dr. Cassel will be stepping down at her position at ABIM to become President and CEO of the National Quality Forum in July 2013.

Dr. Cassel is one of 20 scientists chosen by President Obama to serve on the President's Council of Advisors on Science and Technology (PCAST), which advises the President in areas where an understanding of science, technology, and innovation is key to forming responsible and effective policy. She is the co-chair and physician leader of PCAST working groups that have made recommendations to the President on issues relating to health information technology and ways to promote scientific innovation in drug development and evaluation.

In addition to having chaired influential Institute of Medicine (IOM) reports on end-of-life care and public health, she served on the IOM's Comparative Effective Research Committee mandated by Congress to set priorities for the national CER effort (PCORI). *Modern Healthcare* has recognized Dr. Cassel among the 100 most influential people in health care, and among the 50 most influential physicians. An active scholar and lecturer, she is the author or co-author of 14 books and more than 200 journal articles on geriatric medicine, aging, bioethics and health policy. She edited four editions of *Geriatric Medicine*, a leading textbook in the field. Her most recent book is *Medicare Matters: What Geriatric Medicine Can Teach American Health Care*.

A national leader in efforts to inspire quality care, Dr. Cassel was a founding member of the Commonwealth Fund's Commission on a High Performance Health System, and served on the IOM committees that wrote the influential reports *To Err is Human* and *Crossing the Quality Chasm*. She was appointed by President Clinton to the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry in 1997.
Dr. Cassel is also respected as a scientific leader, having served on the Advisory Committee to the NIH Director, 1995 – 2002, and as President of the American Federation for Aging Research. She is an Adjunct Professor of Medicine and Senior Fellow in the Department of Medical Ethics and Health Policy at the University of Pennsylvania School Of Medicine. Dr. Cassel's previous positions include dean of the School of Medicine and vice president for medical affairs at Oregon Health and Science University, chair of the Department of Geriatrics and Adult Development at Mount Sinai School of Medicine in New York, and chief of General Internal Medicine at the University of Chicago.

Dr. Cassel, board certified in internal medicine and geriatric medicine, is a former Chair of the ABIM Board of Directors, and is a former President of the American College of Physicians. Recipient of numerous international awards and honorary degrees, Dr. Cassel is an Honorary Fellow of the Royal Colleges of Medicine of the U.K. and Canada, the European Federation of Internal Medicine, and is a Master of the American College of Physicians.

Dan Crippen, PhD
Executive Director, National Governors Association

Dan Crippen serves as the executive director of the National Governors Association (NGA). As executive director, he works with governors to identify and prioritize the most pressing issues facing states and oversees the day-to-day operations of the association. Founded in 1908, NGA is the only bipartisan organization of the

nation's governors. NGA promotes visionary state leadership, shares best practices and speaks with a unified voice on national policy.

Crippen brings a wealth of experience in state and federal budgets, health care and retirement issues. Prior to his work at NGA, Crippen served as the director of the Congressional Budget Office from 1999 to 2002, supporting the Congressional budget process and providing expert analysis to guide and inform economic decision making.

Since CBO, Crippen has worked in the private and non-profit sectors primarily on health care – including Medicaid, health IT, and health care for elderly and complex patients.

In the early 1980s, during a time of great economic upheaval and uncertainty, Crippen served as the Chief Counsel and Economic Advisor for Senate Majority Leader Howard Baker. This position paved the way for his role as the Deputy Assistant to the President for Economic Policy and Assistant to the President for Domestic Policy under the Reagan administration, from 1987 to 1989.

Crippen is a member of the Board of Trustees for the Center for Health Care Strategies, a non-profit health policy center focusing on Medicaid; a member of the board of Father Martin's Ashley, a drug and alcohol rehab center; and a member of the CBO Economic Advisors. He has also served as senior advisor to the chairman of the Securities and Exchange Commission and as a member of the CEO Health Transformation Community, the NASA Aeronautics and Safety Advisory Panel and the Google Health Advisory Committee.

Crippen completed his undergraduate work at The University of South Dakota and earned a PhD and a master's degree in public finance from The Ohio State University.

Jay Crosson, MD
Group Vice President, Professional Satisfaction, Care Delivery and Payment, American Medical Association

On July 1, 2012, Dr. Crosson assumed the position of Group Vice President-Physician Satisfaction: Care Delivery and Payment with the American Medical Association. Previously, he was the founding Executive Director of The Permanente Federation, the national organization of the Permanente Medical Groups, the physician component of Kaiser Permanente. He also served as a Senior Fellow in the Kaiser Permanente Institute for Health Policy, where in 2010, he co-authored a book entitled, "*Partners in Health: How Physicians and Hospitals Can Be Accountable Together."*

Dr. Crosson is Past Chair of the Governing Board of the American Medical Group Association (AMGA). In 2002, Dr. Crosson founded and for ten years led the Council of Accountable Physician Practices (CAPP), an AMGA affiliate. He previously served for nine years on the California Medical Association Board of Trustees, and on the Congressional Medicare Payment Advisory Commission (MedPAC), from 2004-2010. He was appointed Vice-Chairman of MedPAC from 2009-2010. He is a graduate of the Kaiser Permanente Executive Program at Stanford Business School.

Dr. Crosson received an undergraduate degree in Political Science and, in 1970, a medical degree from Georgetown University. He completed a residency in Pediatrics at the New England Medical Center Hospitals and a fellowship in Infectious Diseases at the Johns Hopkins University Medical School. He is certified by the American Board of Pediatrics. He served as a physician in the U.S. Navy at the Bethesda National Naval Medical Center from 1973-75.

David Cutler, PhD
Otto Eckstein Professor of Applied Economics, Harvard University

David Cutler has developed an impressive record of achievement in both academia and the public sector. He served as Assistant Professor of Economics from 1991 to 1995, was named John L. Loeb Associate Professor of Social Sciences in 1995, and received tenure in 1997. He is currently the Otto Eckstein Professor of Applied Economics in the Department of Economics and holds secondary appointments at the Kennedy School of Government and the School of Public Health. Professor Cutler was associate dean of the Faculty of Arts and Sciences for Social Sciences from 2003-2008.

Honored for his scholarly work and singled out for outstanding mentorship of graduate students, Professor Cutler's work in health economics and public economics has earned him significant academic and public acclaim. Professor Cutler served on the Council of Economic Advisers and the National Economic Council during the Clinton Administration and has advised the Presidential campaigns of Bill Bradley, John Kerry, and Barack Obama as well as being Senior Health Care Advisor for the Obama Presidential Campaign. Among other affiliations, Professor Cutler has held positions with the National Institutes of Health and the National Academy of Sciences. Currently, Professor Cutler is a Research Associate at the National Bureau of Economic Research, a member of the Institute of Medicine, and a Fellow of the Employee Benefit Research Institute. He advises many companies and groups on health care.

Professor Cutler was a key advisor in the formulation of the recent cost control legislation in Massachusetts, and is one of the members of the Health Policy Commission created to help reduce medical spending in that state.

Professor Cutler is author of two books, several chapters in edited books, and many of published papers on the topics of health care and other public policy topics. Author of *Your Money Or Your Life: Strong Medicine for America's Health Care System*, published by Oxford University Press, this book, and Professor Cutler's ideas, were the subject of a feature article in the *New York Times* Magazine, *The Quality Cure*, by Roger Lowenstein. Cutler was recently named one of the 30 people who could have a powerful impact on healthcare by *Modern Healthcare* magazine and one of the 50 most influential men aged 45 and younger by *Details* magazine.

Professor Cutler received an AB from Harvard University (1987) and a PhD in Economics from MIT (1991).

Karen Davis, PhD
Eugene and Mildred Lipitz Professor,
Johns Hopkins Bloomberg School of Public Health

Dr. Davis is currently the Eugene and Mildred Lipitz Professor in the Department of Health Policy and Management and Director of the Roger C. Lipitz Center for Integrated Health Care at the Bloomberg School of Public Health at Johns Hopkins University. The center strives to discover and disseminate practical, cost-effective approaches to providing comprehensive, coordinated, and compassionate health care to chronically ill people and their families.

Dr. Davis has served as President of The Commonwealth Fund, Chairman of the Department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, and Deputy Assistant Secretary for Health Policy in the Department of Health and Human Services.

In addition, she was a senior fellow at the Brookings Institution in Washington, D.C., a visiting lecturer at Harvard University and an assistant professor of economics at Rice University. She received her Ph.D. in economics from Rice University.

Dr. Davis also serves on the Board of Directors of the Geisinger Health System and Geisinger Health Plan and on the Board of Trustees of ProMedica Health System in Ohio. She is a member of the Kaiser Commission on Medicaid and the Uninsured and the American Academy of Arts and Sciences. She was elected to the Institute of Medicine in 1975, has served two terms on the IOM governing Council (1986-90 and 1997-2000), and is a member of the IOM Committee on Geographic Variation in Health Care Spending. She is also a former member of the Agency for Healthcare Quality and Research (AHRQ) National Advisory Council for Health Care Policy, Research and Evaluation, of the Panel of Health Advisers for the Congressional Budget Office, a past chairman of AcademyHealth from whom she received a Distinguished Investigator Award, recipient of the Baxter-Alliance Foundation Prize for Health Services Research, the Healthcare Financial Management Association Board of Directors Award, and an honorary fellow of the American College of Healthcare Executives.

Susan Dentzer
Senior Policy Adviser, Robert Wood Johnson Foundation

Susan Dentzer is Senior Policy Adviser at the Robert Wood Johnson Foundation, the nation's largest philanthropy focused on health and health care, and an on-air analyst on health issues with the PBS *NewsHour*. She served from 2008 – 2013 as the editor-in-chief of *Health Affairs*, the nation's leading journal of health policy. She also previously led the *NewsHour's* health unit, reporting extensively on-air about health care reform debates. She is an elected member of the Institute of medicine and the Council on Foreign Relations; a fellow of the National Academy of Social Insurance; a fellow of the Hastings Center; and a member of the Kaiser Commission on Medicaid and the Uninsured. Ms. Dentzer graduated from Dartmouth, is a trustee emerita of the college, and chaired the Dartmouth Board of Trustees from 2001 to 2004. She currently serves as a member of the Board of Overseers of Dartmouth Medical School and is an Overseer of the International Rescue Committee, a leading humanitarian organization. She is also on the board of directors of Research!America, an alliance working to make research to improve health a high priority, and is a public member of the Board of Directors of the American Board of Medical Specialties.

Susan DeVore
President and CEO, Premier healthcare alliance
Susan DeVore is president and CEO of the Premier healthcare alliance, the nation's leading alliance of hospitals, health systems and other providers dedicated to improving healthcare performance. An alliance of more than 2,800 hospitals and health systems and more than 93,000 non-acute care sites. Premier uses the power of collaboration to lead the transformation to high-quality, cost-effective healthcare. Premier's membership includes more than 40 percent of all U.S. health systems.

With the ultimate goal of helping its members improve the health of their local communities, Premier builds, tests and scales models that improve quality, safety and cost of care. Through successful initiatives such as the Hospital Quality Incentive Demonstration™ with the Centers for Medicare & Medicaid Services, and the QUEST®: High Performing Hospitals collaborative, the alliance has driven improvements in evidence-based care and safety, as well as significant reductions in mortality, harm and cost. As the nation's largest group purchasing organization, Premier saved hospitals and non-acute care providers nearly $5 billion.

Premier is a leader in the accountable care movement, publishing first-of-its-kind research through the Commonwealth Fund on accountable care readiness and collaborating with hospitals nationwide to design an industry standard capabilities roadmap for designing, delivering and coordinating accountable care. In partnership with member hospitals and leading technology companies, Premier is co-developing a payor and provider data platform to enable health systems to make better decisions based on integrated cost and quality information across the continuum of care. Additionally, Premier's integrated data platform, PremierConnect™, allows health systems to access quality, safety, labor, supply chain, and population health analytic applications while also enabling collaboration and the exchange of best practices.

Under DeVore's leadership, Premier has built an industry-leading code of ethics, has been named six times as one of the World's Most Ethical Companies by Ethisphere, won the Malcolm Baldrige National Quality Award, has been named to InformationWeek's 500 top technology innovators in the nation three years running, and recently won IBM's CTO Innovation award for advanced analytics in healthcare.

DeVore is an industry-leading thinker who was named to Modern Healthcare's 100 Most Influential People in Healthcare and Top 25 Women in Healthcare lists. She is on the boards of the Healthcare Leadership Council, the Coalition to Protect America's Healthcare, the National Center for Healthcare Leadership, and the Medicare Rights Center. She also serves as a member of the Institute of Medicine's Roundtable on Value & Science Driven Health Care.

Karen Wolk Feinstein, PhD
President and Chief Executive Officer, Jewish Healthcare Foundation, Pittsburgh Regional Health Initiative

Dr. Feinstein is President and Chief Executive Officer of the Jewish Healthcare Foundation (JHF) and its two supporting organizations, the Pittsburgh Regional Health Initiative (PRHI) and Health Careers Futures (HCF). Together they offer a unique alchemy of grant making, research, teaching, coaching, resource development, and project management. Appointed the Foundation's first CEO in 1990, she initially guided the Foundation to a focus on aging, women's health and underserved populations. The JHF won national awards for its work on childhood immunizations, breast cancer, and HIV/AIDs.
She has since made JHF and PRHI a leading voice in patient safety, healthcare quality and related workforce issues. When Dr. Feinstein founded PRHI, it was among the nation's first regional multi-stakeholder quality coalitions devoted simultaneously to advancing efficiency, best practices, and safety by applying industrial engineering principles. Dr. Feinstein also founded Health Careers Futures to assist the region's healthcare industry in attracting, preparing, and retaining employees, and was a leader in the formation of the Network for Regional Healthcare Improvement (NRHI), a national coalition of Regional Health Improvement Collaboratives.

Dr. Feinstein is regarded as a national leader in healthcare quality improvement and frequently presents at national and international conferences. She is the author of numerous regional and national publications on quality and safety. In a previous life, she was the editor of the *Urban & Social Change Review*, and she is the editor of a new book *Moving Beyond Repair: Perfecting Health Care*. Additionally, she has served on the faculties of Boston College, Carnegie Mellon University, and the University of Pittsburgh.

Dr. Feinstein has held executive professional and trustee posts at other non-profits, including the United Way and the Allegheny Conference, and is a Past President of Grantmakers In Health and Grantmakers of Western Pa, and co-chair of the Pennsylvania Health Funders Collaborative. She serves on many non-profit, governmental and for-profit boards, including NRHI, the Center for Innovation Advisory Committee at the National Board of Medical Examiners, the Board of Overseers at Brandeis University's Heller School, and on the Health Research Advisory Committee of the Pennsylvania Department of Health.

Dr. Feinstein earned her bachelor's degree at Brown University, her master's at Boston College, and her doctorate at Brandeis University.

Richard Foster, FSA, MAAA
Chief Actuary, Retired, Centers for Medicare and Medicaid Services

Mr. Foster retired in February 2013 after serving as Chief Actuary for the Centers for Medicare & Medicaid Services since 1995. As director of the Office of the Actuary, he was responsible for all actuarial and other financial analyses for the Medicare and Medicaid programs. This work involved both the evaluation of the financial status of the programs under current law and the estimation of the financial effects of legislative proposals. In addition, Mr. Foster oversaw the preparation of the widely used national health expenditure account data and projections, the estimation of the financial effects of national health reform proposals, the determination of the hospital input price index, Medicare Economic Index, and other price indexes used to update Medicare payments to providers, the calculation of the Medicare Advantage payment benchmarks for private health plans that contract with Medicare, and the review of the actuarial bid submissions for all Medicare Advantage and Part D plans.

Prior to 1995, Mr. Foster served as Deputy Chief Actuary for the Social Security Administration for 13 years. He is a Fellow of the Society of Actuaries (1980) and a member of the American Academy of Actuaries, American Statistical Association, American Economic Association, and National Academy of Social Insurance. He has written numerous articles and reports on Medicare and Social Security issues, including "Level of OASDI Trust Fund Assets Needed To Compensate for Adverse Contingencies" in *Transactions of the Society of Actuaries* (1993), "A Stochastic Evaluation of the Short Range Economic Assumptions in the 1994 OASDI Trustees Report," and "Trends in Medicare Expenditures and Financial Status, 1966-2000" and "Medicare Financial Status, Budget Impact, and Sustainability: Which Concept is Which?" in the *Health Care Financing Review*. Mr. Foster has testified before Congress on numerous occasions and has made more than 200 other presentations on Medicare, Medicaid, national health insurance, and Social Security issues.

Mr. Foster received an MS in applied mathematics from the University of Maryland, Baltimore County, and a B.A. in mathematics from the College of Wooster. He has received a number of awards, including the UMBC Outstanding Alumnus of the Year in 1997, the Presidential Meritorious Executive Award in 1998 from President Clinton, CMS Administrator's Achievement Awards in 1999, 2003, and 2010, the Presidential Distinguished Executive Award in 2001 from President Bush, the College of Wooster Distinguished Alumni Award in 2006, the Robert J. Myers Public Service Award from the American Academy of Actuaries in 2006, the Wynn Kent Public Communication Award in 2011, and the Society of Actuaries' President's Award in 2011. In 2007 through 2012, the readers of *Modern Healthcare* have voted Mr. Foster one of the 100 most influential persons in health care in the U.S.

Elizabeth Fowler, JD
Vice President, Global Health Policy, Johnson & Johnson

Elizabeth Fowler is Vice President, Global Health Policy, in the Government Affairs & Policy group at Johnson & Johnson. Liz joins Johnson & Johnson from the White House, where she served as Special Assistant to the President for Healthcare and Economic Policy at the National Economic Council. She joined NEC after serving as Deputy Director for Policy of the Center for Consumer Information and Insurance Oversight (OCIIO) at the U.S. Department of Health and Human Services, the new agency tasked with implementing the insurance market reforms included in the Affordable Care Act (ACA). During the health reform debate, Liz served as Chief Health Counsel and Senior Counsel to the Chair to Senate Finance Committee Chairman, Senator Max Baucus (D-MT), where she played a critical role in developing the Senate version of health reform. In a previous stint with the Finance

Committee, she also played a key role in the 2003 Medicare Prescription Drug, Improvement and Modernization Act (MMA). Liz has more than 20 years of experience in health services research and health policy. She served as vice president of public policy and external affairs for WellPoint, Inc. and as an attorney with the Washington law firm Hogan & Hartson. She also spent nearly five years as a health services researcher with HealthSystem Minnesota. Liz has a BA from the University of Pennsylvania, a PhD from the Johns Hopkins School of Public Health, where her research focused on risk adjustment, and a law degree (JD) from the University of Minnesota. She is admitted to the bar in Maryland and the District of Columbia.

Heather Howard, JD
Director, State Quality and Value Strategies,
Princeton University

Heather Howard is a lecturer in Public Affairs at Princeton University's Woodrow Wilson School of Public and International Affairs and director of two Robert Wood Johnson Foundation-funded programs: the State Health Reform Assistance Network provides technical assistance to states implementing the Affordable Care Act and State Quality and Value Strategies works with states to develop sustainable health care quality and value initiatives. She served as New Jersey's Commissioner of Health and Senior Services from 2008-2010, overseeing a cabinet-level agency with a budget of $3.5 billion and staff of 1,700 responsible for public health services, regulation of health care institutions, senior services, and health care policy and research. Previously, she served as Governor Corzine's Chief Policy Counsel, directing his policy agenda. She also has significant federal experience, having worked as Senator Corzine's Chief of Staff, as Associate Director of the White House Domestic Policy Council and as Senior Policy Advisor for First Lady Hillary Clinton, as an Honors Attorney in the U.S. Department of Justice's Antitrust Division Health Care Task Force, and for the U.S. House of Representatives.

Howard received her JD *cum laude* from New York University School of Law, serving a judicial clerkship with Judge Martha Craig Daughtrey of the U.S. Court of Appeals for the Sixth Circuit, and her BA *cum laude* from Duke University.

Jon Kingsdale, PhD
Managing Director, Wakely Consulting Group

Jon Kingsdale is a Managing Director of the Wakely Consulting Group. He has consulted to CMS and over a dozen states, on implementation of PPACA generally, and American Health Benefit Exchanges in particular.

Jon was the founding Executive Director of the Health Connector, established under Massachusetts' landmark health reform legislation. Prior to that, Jon worked in health insurance, the Harvard School of Public Health, and Forbes Magazine.

Bernadette Loftus, MD
Associate Executive Director,
The Permanente Medical Group

Bernadette C. Loftus, MD, has been with The Permanente Medical Group (TPMG) since 1991. She has held a number of roles in TPMG in her two-decade career, including TPMG Board member and Assistant Secretary of the Board; Physician-in-Chief of the Santa Clara Medical Center; and Assistant Chief, Department of Otolaryngology/Head & Neck Surgery. She is currently Associate Executive Director, and the executive in charge of the Mid Atlantic Permanente Medical Group, acquired by TPMG in 2008. In this role, she partners with the President of the Kaiser Foundation Health Plan of the Mid-Atlantic States, which cares for approximately 500,000 members in Washington D.C, Maryland and Virginia. Dr. Loftus has hired more than 350 Mid Atlantic Permanente physicians in less than four years, and has led significant improvements in HEDIS and CAHPS quality and service measures. For 2012, Kaiser Permanente of the Mid-Atlantic States ranked #1 in the country on four HEDIS® (the Healthcare Effectiveness Data and Information Set) measures of clinical excellence: Breast Cancer Screening, Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis, Childhood Immunization Hepatitis A, and Comprehensive Diabetes Care: Nephropathy Screening. In 2012, Kaiser Permanente Mid-Atlantic States was ranked #1 by the National Committee for Quality Assurance (NCQA) in Maryland, DC, and Virginia, and was the #15 plan in the nation. For the fifth consecutive year, J.D. Power and Associates ranks Kaiser Permanente of the Mid-Atlantic States highest in member satisfaction in the Mid Atlantic geography.

Dr. Loftus currently serves on the Board of Directors of the American Medical Group Association. She is a Commissioner on the State of Maryland's Health Services Cost Review Commission. She is also on the Board of Directors for The JW House Foundation in California; and, until 2011, was a member of the Research Advisory Board of the American Academy of Otolaryngology, Alexandria, Virginia. She is often invited to be a guest speaker on a variety of health care topics for such entities as the Wharton School of Business of the University of Pennsylvania; the AMGA Annual Conference; the National Health Service of the United Kingdom; and The Commonwealth Fund. Her broader health care interests lie in technology-enabled population care management; leadership for rapid performance improvement; and using data and transparency to drive performance.

A member of Alpha Omega Alpha Honor Society, Dr. Loftus has received the 2003 Silicon Valley Business Woman the Year; the 2007 Woman of the Year, California State Senate District 13; and the Benjamin Corey Leadership Award presented by the Santa Clara County Medical Association in 2009.

After earning her B.A. and graduating with honors from the University of Pennsylvania, Dr. Loftus received her M.D. from Case Western Reserve University School of Medicine, Cleveland (with honors) and did preliminary general surgery residency at Albert Einstein Medical Center, Philadelphia, and Otolaryngology/Head and Neck Surgery residency at Columbia University, New York, where she was also appointed Chief Resident in Head and Neck Surgery. Dr. Loftus is Board-certified in Otolaryngology/Head and Neck Surgery.

Mark Miller, PhD
Executive Director, Medicare Payment Advisory Commission

Mark Miller, PhD is the Executive Director of the Medicare Payment Advisory Commission (MedPAC), a nonpartisan federal agency that

advises the U.S. Congress on Medicare payment, quality, and access issues. Dr. Miller has more than 20 years of health policy experience and has held several policy, research, and management positions in health care, including Assistant Director of Health and Human Resources (HHR) at the Congressional Budget Office; Deputy Director of Health Plans at the Centers for Medicare and Medicaid Services, Health Financing Branch Chief at the Office of Management and Budget, and Senior Research Associate at the Urban Institute. He earned a PhD in public policy analysis from the State University of New York at Binghamton.

Greg Moody, MA
Director, Governor's Office of Health Transformation, State of Ohio

Governor John R. Kasich appointed Greg Moody in January 2011 to lead the Office of Health Transformation. OHT is responsible for advancing Governor Kasich's Medicaid modernization and cost-containment priorities, engaging private sector partners to improve overall health system performance, and recommending a permanent health and human services structure for Ohio.

Greg began his public service career as a budget associate for the U.S. House Budget Committee in Washington D.C. The Budget Chairman at the time, Rep. John Kasich, asked Greg to study the impact of Medicaid on federal spending – an assignment that set the course for his public policy career.

Prior to joining the Kasich Administration, Greg was a senior consultant at Health Management Associates, a national research and consulting firm that specializes in complex health care program and policy issues. He worked with clients to improve Medicaid system performance, and wrote extensively about state health system innovations for the Commonwealth Fund, National Governor's Association, and other foundations.

Greg's Ohio experience includes serving as Interim Director of the Ohio Department of Job and Family Services (2001), Executive Assistant for Health and Human Services for Governor Bob Taft (1999-2004), and Chief of Staff to the Dean at the OSU College of Medicine (1997-1999).

Greg has a Masters in Philosophy from George Washington University and Bachelors in Economics from Miami University.

Len Nichols, PhD
Director, Center for Health Policy Research and Ethics, College of Health and Human Services, George Mason University

Len Nichols became Director of the Center for Health Policy Research and Ethics (CHPRE) and a Professor of Health Policy at George Mason University on March 1, 2010. As he works to strengthen CHPRE's connections to national, state, and private sector conversations about ways to improve the performance, sustainability, and equity of the US health care system, he continues to bridge the worlds of health policy, health politics, health economics, health services research, and to help make sense of it all for policy makers, private sector leaders, other researchers, and journalists. Len's most recent prior position was Director of the Health Policy Program at the New America Foundation, where he contributed to the national health reform debate through testimony, briefings, writing, news commentary, and public speaking. He has been intimately involved in health reform debates, policy development, and communication for over 18 years, and is one of the few analysts in Washington that maintains the respect and engagement of elected officials from both sides of the aisle. In addition to testimony Len often is asked to provide technical expertise to members of Congress, governors, state legislators, and other policy officials around the country. He has consistently sought to add moral arguments to the technical health policy debate, and in so doing helps journalists and others remember why the issue is so important to our country. Because of his reputation as an unbiased and knowledgeable health reform analyst, he is frequently interviewed and quoted by major media outlets including the New York Times, Washington Post, Los Angeles Times, National Journal, the Wall Street Journal, Time and Newsweek magazines, National Public Radio, Lerher News Hour, the British Broadcasting Service, NBC Nightly News, ABC News Tonight, and CBS Evening News. As recent as February 2012, Len has testified before both the House Committee on Ways and Means as well as the Senate Budget Committee.

Len was recently selected to be an Innovation Advisor to the Center for Medicare and Medicaid Innovation and is an advisor to the Virginia Center for Health Innovation as well. He is the Principle Investigator of a 5 year evaluation of CareFirst's Patient Centered Medical Home/Total Care and Cost Improvement program. He has served as Vice President of the Center for Studying Health System Change, a Principal Research Associate at the Urban Institute and as the Senior Advisor for Health Policy at the Office of Management and Budget (OMB) in the Clinton Administration. Len was also a visiting Public Health Service Fellow at the Agency for Health Care Policy and Research during 1991-1992, and prior to that he was an Associate Professor and Economics Department Chair at Wellesley College, where he taught from 1980-1991.

Sandy Praeger
Insurance Commissioner, State of Kansas, Chair of NAIC Health and Managed Care Committee

Commissioner Sandy Praeger was elected Kansas' 24th Commissioner of Insurance in 2002 and began serving on Jan. 13, 2003. She was re-elected in 2006 and again in 2010. Commissioner Praeger is responsible for regulating all insurance sold in Kansas and overseeing the nearly 1,700 insurance companies and 101,000 agents licensed to do business in the state.

Commissioner Praeger serves as Chair of the Health Insurance and Managed Care Committee for the National Association of Insurance Commissioners and NAIC past president. She is frequently called upon by media and called to testify before Congress on health reform.

She is a two-time recipient of the prestigious Dr. Nathan B. Davis Award, bestowed annually by the American Medical Association to individuals who have made a significant contribution to the public health through elected and career government service. Commissioner Praeger is a graduate of the University of Kansas and lives in Lawrence, KS, with her husband, Dr. Mark Praeger. They have two married children and three grandchildren.

Uwe Reinhardt, PhD
James Madison Professor of Political Economy,
Princeton University

Uwe E. Reinhardt is the James Madison Professor of Political Economy and Professor of Economics, Princeton University, USA, where he teaches health economics, comparative health systems, general micro-economics and financial management. The bulk of his research has been focused on health economics and policy, both in the U.S. and abroad.

Recognized as one of the leading U.S. authorities on health care economics and health policy, Reinhardt serves, or has served, on a number of government care, number of commissions and advisory boards, among them the Physician Payment Review Commission (now part of Medicare Payment Advisory Commission, or Medpac), a commission established by the U.S. Congress to advise it on issues related to physician payment; the National Council on Health Care Technology of the U.S. Department of Health, Education and Welfare (now Department of Health and Human Services (DHHS)); the Special Advisory Board of the VA; the National Advisory Board of the Agency for Health Care Quality and Research, DHHS.

He is a member of the Institute of Medicine and served on its Governing Council in the 1980s. He is past president of the Association of Health Services Researchers (now Academy Health), and of the Foundation for Health Services Research. He is also past president of the International Health Economics Association on whose Executive Committee he still serves. He also is a Commissioner of the Kaiser Family Foundation Commission on Medicaid and the Uninsured. He has been a trustee of Duke University and also of the Duke University Health System, and has served or still serves as director of several health care-related corporations.

He is a trustee of the National Bureau of Economic Research (NBER), and also serves on the board of the National Institute of Health Care Management and is chairman of the coordinating committee of the Commonwealth Fund's International Program in Health Policy. He is a senior associate of the Judge Institute for Management of Cambridge University, UK. He served on the World Bank External Advisory Panel for Health, Population and Nutrition. In October 2006 Reinhardt was appointed by Governor John Corzine of New Jersey to chair the health reform commission for the state.

Reinhardt is or was a member of numerous editorial boards, among them the New England Journal of Medicine, the Journal of the American Medical Association, the Journal of Health Economics, Health Affairs, and the Milbank Memorial Quarterly.

His academic honors include the Governor's Gold Medal of the University of Saskatchewan in Canada, several honorary doctorates, the Federal Merit Cross bestowed by Germany's President and the William B. Graham Prize for Health Services Research, also known as the Baxter Prize.

Robert Reischauer, PhD
Distinguished Fellow and President Emeritus,
The Urban Institute

Robert D. Reischauer, PhD is a Distinguished Institute Fellow and President Emeritus of the Urban Institute, a non-profit, non-partisan policy research and education organization that he was the president of from 2000 to 2012. Between 1989 and 1995, he served as the director of the Congressional Budget Office (CBO). He also served as CBO's deputy director, assistant director for Health, Retirement and Long-Term Analysis and executive assistant to the director between 1975 and 1981. Reischauer has been a senior fellow (1986-89 and 1995-2000) and Research Associate (1970-75) in the Economic Studies Program of the Brookings Institution and the senior vice president of the Urban Institute (1981-86).

Reischauer, who holds an AB from Harvard and a Masters in International Affairs and a PhD in economics from Columbia University, is one of two public trustees of the Social Security and Medicare Trust Funds. He is a founding Member of the Academy of Social Insurance and a member of the American Academy of Arts and Science, the Institute of Medicine, the National Academy of Public Administration and CBO's Panel of Health Advisers. He was a member of the Medicare Payment Advisory Commission (MedPAC) from 2000-09 serving as its vice chair from 2001-08. He chaired the National Academy of Social Insurance's project, "Restructuring Medicare for the Long Term" from 1995 to 2004. Reischauer, who serves on the boards of several non-profit organizations, is the Senior Fellow of the Harvard Corporation.

Trish Riley, MS
Visiting Fellow and Lecturer in State Health Policy,
George Washington University

Trish Riley is a Lecturer in State Health Policy at George Washington University, where she previously served as a Distinguished Fellow, and an Adjunct Professor of Health Policy at the Muskie School of Public Service, University of Southern Maine. She served as Director of Governor Baldacci's Office of Health Policy and Finance, from 2003 – 2011, leading the effort to develop a comprehensive, coordinated health system in Maine and to assure affordable health insurance for all Maine citizens. She was the principal architect of Dirigo Health Reform and served as the state's liaison to the federal government and Congress, particularly during deliberations around national health reform. She chaired the Governor's Steering Committee to develop a plan to implement the Affordable Care Act in Maine.

Riley previously served as Executive Director of the National Academy for State Health Policy and President of its Corporate Board from 1989-2003. There she built a major national organization, regularly called upon by policy officials and the press. She has also held appointive positions under four Maine governors, including directing the aging office, Medicaid and state health agencies, including health planning and licensing programs.

Riley has published and presented widely about state health reform. She serves as a member of the Kaiser Commission on Medicaid and the Uninsured, the Medicaid and CHIP Payment and Access Commission and was a member of the Institute of Medicine's Subcommittee on Creating an External Environment for

Quality. She also previously served as a member of the Board of Directors of the National Committee on Quality Assurance. Riley holds a BS & MS from the University of Maine.

C. Eugene Steuerle, PhD
Institute Fellow and Richard B. Fisher Chair,
Urban Institute

Eugene Steuerle serves in the Richard B. Fisher Chair at the Urban Institute. Among his previous positions, he has served Deputy Assistant Secretary of the Treasury for Tax Analysis, President of the National Tax Association, chair of the 1999 Technical Panel advising Social Security on its methods and assumptions, and Vice-President of the Peter G. Peterson Foundation. He is a co-founder of the Urban-Brookings Tax Policy Center, the Urban Institute Center on Non-profits and Philanthropy, and ACT for Alexandria, a community foundation. From 1984 to 1986, he worked as the original organizer and economic coordinator of the Treasury Department's tax reform effort leading to the Tax Reform Act of 1986. Among many books are *Contemporary U.S. Tax Policy (2nd edition).*

Dr. Steuerle has served as an advisor to President Obama's debt commission and a member of the Peterson-Pew Commission on Budget Reform. He has also served on the National Committee on Vital and Health Statistics and has published many articles on the financing of health care, the use of mandates, and the design, administration, and economic effect of health insurance subsidies. He has testified many times before Congress and served as "faculty" at health reform retreats of by both the Senate Finance Committee and the House Ways and Means Committee.

David Sundwall, MD
Professor of Public Health,
University of Utah School of Medicine

David Sundwall, MD, is a Professor of Public Health [clinical] at the University of Utah - School of Medicine, Division of Public Health, where he has been a faculty member since 1978 (albeit with a very long leave of absence in Washington DC, from 1981-2005). He served as Executive Director of the Utah Department of Health and Commissioner of Health for the State of Utah, from 2005 through 2010. He currently serves on numerous government and community boards and advisory groups including Chair of the Utah State Controlled Substance Advisory Committee and as Vice Chair of the federal Medicaid and CHIP Payment and Access Commission [MACPAC] in Washington D.C.

Dr. Sundwall was President of the Association of State and Territorial Health Officials (ASTHO) from 2007-8. He has chaired or served on several committees of the Institute of Medicine (IOM) – currently on the Standing Committee on Health Threats Resilience, and on the Committee on Department of Homeland Security Occupational Health and Operational Medicine Infrastructure.

Prior to returning to Utah in 2005, he was President of the American Clinical Laboratory Association (ACLA) and prior to that was Vice President and Medical Director of American Healthcare Systems (AmHS). Dr. Sundwall's federal government experience includes serving as Administrator of the Health Resources and Services Administration (HRSA), Assistant Surgeon General in the Commissioned Corps of the U.S. Public Health Service, and Director of the Health and Human Resources Staff of the Senate Labor and Human Resources Committee. He received his medical degree from the University of Utah - School of Medicine, and completed residency in the Harvard Family Medicine Program. He is a licensed physician, board certified in Internal Medicine and Family Practice, and provides primary care in a public health clinic two-half days each week.

Anya Rader Wallack, PhD
Chair, Green Mountain Care Board

Anya Rader Wallack, Chair of the Green Mountain Care Board, has worked in health care policy and reform for the past two decades. In January 2011, Ms. Wallack joined Governor Shumlin as Special Assistant for Health Reform and was the chief architect of Act 48, the Governor's health reform plan. During the 1990's Ms. Wallack served as Governor Howard Dean's Deputy Chief of Staff and focused on health reform. Additionally, Ms. Wallack served on Hillary Clinton's Health Reform Task Force. Upon leaving the Dean administration, Ms. Wallack became the Executive Director of the Vermont Program for Quality in Health Care and a member of the Vermont Board of Medical Practice.

More recently, Ms. Wallack led the Massachusetts Medicaid Policy Institute and was also interim President of the Blue Cross Blue Shield of Massachusetts Foundation. She chaired the Massachusetts Health Care Quality and Cost Council's committee on cost containment, and served on the Rhode Island Health Reform Task Force. Ms. Wallack has been a consultant on state-based health reform to states, non-profits, foundations and health care providers for much of the past decade.

Ms. Wallack is a native Vermonter and graduate of the University of Vermont. She holds a PhD in Social Policy from Brandeis University and lives in Montpelier.

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Steven T. Wray, MS
Executive Director, Economy League of Greater Philadelphia

Steve Wray was named Executive Director of the Economy League of Greater Philadelphia in 2006. He works with a board of more than 70 senior private sector leaders from the region's leading companies and institutions and a staff of 8. Wray also is Managing Director of the Pennsylvania Economy League, Inc., the corporate home of the Economy League of Greater Philadelphia.

Prior to the Economy League, Wray served as Policy Director to Pennsylvania Lt. Governor Mark Singel, Associate with Jones Lang Wootton USA in New York, and Consultant to the Executive Director of the Allegheny Conference on Community Development in Pittsburgh.

In 2010, Wray began a two-year term on the Pennsylvania Early Learning Investment Commission and was appointed to the Advisory Board for the Office of Economic Opportunity in Philadelphia. He is a trustee of the Health Care Improvement Foundation and a member of the Aria Health Board of Directors and the Board and Executive Committee of the Philadelphia Convention& Visitors Bureau. He was a 2008 Ford Foundation Fellow of the American Chamber of Commerce Executives' Regional Sustainable Development program, and in 2002 he was named to the Philadelphia Business Journal's "40 Under 40" leadership list. Wray received an MS in Public Management and Policy from Carnegie Mellon University and an AB from Duke University. He lives in Newtown, Bucks County, Pennsylvania.