SYMPOSIUM ON SUSTAINABLE U.S. HEALTH SPENDING

SUSTAINABLE U.S. HEALTH SPENDING
Cost Control with Improved Value?

Washington, DC · Tuesday, July 9, 2019

SYMPOSIUM MONOGRAPH

Paul Hughes-Cromwick and Samantha Clark, Editors
November 2019

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This monograph is the result of a meeting held in Washington, DC, on July 9, 2019. It is the ninth such meeting organized by the Atarum Center for Value in Health Care, and was supported by the Robert Wood Johnson Foundation for the eighth consecutive year. We are grateful to the foundation for its continued support that has imparted visibility and prestige to the event. The content is solely the responsibility of the authors and does not necessarily represent the views of the Robert Wood Johnson Foundation.

In particular, we thank Katherine Hempstead, our Robert Wood Johnson Foundation program officer, for her guidance, wisdom, and enthusiasm. The foundation’s support of our Health Sector Economic Indicators℠—a product that is linked to the symposium funding—stimulates us to track important developments and keep pace with emerging trends affecting the health economy.

We received valuable advice guiding the entire symposium project from our colleagues Ani Turner, George Miller and Corwin Rhyan. Superb editorial input and formatting was provided by Ruth Shamraj and Tad Lee.

Please note: We have edited the July 9, 2019 presentations for clarity, and have added links, some of which stem from activities occurring after the symposium.

A complete (4-hour) video of the event is available at: https://altarum.org/publications/sustainable-us-health-spending-cost-control-improved-value, as are the full set of slide decks.

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**CONTRIBUTORS**

Niall Brennan was appointed President and CEO of the Health Care Cost Institute in June 2017. In this role, he is responsible for all aspects of the HCCI mission, promoting HCCI’s research agenda, examining cost trends in U.S. healthcare, ensuring maximal use of the HCCI data resources to enable world class research and analysis by external users, leading HCCI’s Medicare Qualified Entity business, and working with state and national policy makers to improve the health care system. He is a nationally recognized expert in health care policy, the use of health care data to enable and accelerate health system change, and data transparency.

Michael Chernew, PhD, is the Leonard D. Schaeffer Professor of Health Care Policy and the director of the Healthcare Markets and Regulation (HMR) Lab in the Department of Health Care Policy at Harvard Medical School. Dr. Chernew’s research examines several areas related to controlling health care spending growth while maintaining or improving quality of care. His work on consumer incentives focuses on Value-Based Insurance Design (VBID), which aligns patient cost sharing with clinical value. His work on payment reform involves the evaluation of population-based and episode-based payment models. Other areas of research examine Medicare Advantage, prescribing patterns and medication adherence, the causes and consequences of rising health care spending, and geographic variation in spending, spending growth and quality.

Sabrina Corlette is a Research Professor at the Center on Health Insurance Reforms (CHIR) at Georgetown University’s Health Policy Institute. At CHIR she directs research on health insurance reform issues. Her areas of focus include state and federal regulation of private health insurance plans and markets and evolving insurance market rules. She provides expertise and strategic advice to individuals and organizations on federal and state health insurance laws and programs and provides technical support through the publication of resource guides, white papers, issue briefs, blogs and fact sheets.

Rena M. Conti, PhD, is the Associate Research Director of Biopharma & Public Policy for the Boston University Institute for Health System Innovation & Policy. She is also an Associate Professor at the Boston University Questrom School of Business. From 2006 through June 2018, Professor Conti was an Associate Professor of Health Economics and Policy at the University of Chicago Medical School and the Harris School of Public Policy. Dr. Conti is a health economist. Her research focuses on the organization, financing and regulation of medical care. She has written extensively on the pricing, demand and supply of prescription drugs.

Susan Dentzer is one of the nation’s most respected health policy experts and thought leaders, and a Visiting Fellow at the Robert J. Margolis Center for Health Policy at Duke University. Based in Washington, DC, she works on a range of health policy issues including health system transformation and biopharmaceuticals policy. She is the editor and lead author of the book “Health Care Without Walls: A Roadmap for Reinventing U.S. Health Care,” published in October 2018 on Amazon.com. Dentzer previously led the Network for Excellence in Health Innovation, a nonprofit that sought to advance innovation in health care.

Marc Goldwein is the Senior Vice President and Senior Policy Director for the Committee for a Responsible Federal Budget, where he guides and conducts research on a wide array of topics related to fiscal policy and the federal budget. He is frequently quoted in a number of major media outlets and works regularly with Members of Congress and their staffs on budget-related issues.
Ziad Haydar, MD, MBA, was Senior Vice President, Chief Clinical Officer, Ascension. Dr. Haydar led the organization’s Care Excellence initiatives focusing on the quadruple aim of excellence in quality, service, provider experience, and value creation. In his role, Dr. Haydar oversaw the Ascension Medical Group, and worked with individual market leaders to hardwire excellence and transform care.

Katherine Hempstead, PhD, is senior adviser to the executive vice president, joined the Foundation in 2011. Since late 2013, Hempstead has directed the Robert Wood Johnson Foundation’s work on health insurance coverage. In addition, she works on issues related to health care price transparency and value. Previously, Hempstead was director of the Center for Health Statistics in the New Jersey Department of Health and Senior Services. She also served as statistician/analyst in the Office of the Attorney General, New Jersey Department of Law and Public Safety, and as an assistant research professor at the Rutgers Center for State Health Policy, where she currently holds a visiting faculty position. Hempstead also held positions at New York University’s Wagner School of Public Service, and at Catholic University, in Washington D.C. She completed a postdoctoral fellowship at the Office of Population Research at Princeton University.

Born in New Jersey, Hempstead received a PhD in Demography and History from the University of Pennsylvania, where she also earned a BA in Economics and History.

Joanne Kenen is the health care editor of Politico. Kenen has covered everything from Haitian voodoo festivals to U.S. presidential campaigns. (Sometimes it’s hard to tell the difference.) Since arriving in Washington in 1994, she has focused on health policy and health politics. She joined POLITICO in Sept. 2011.

Kenen got the newspaper bug in second grade (the Teeny Town News), spent way too much time at the Harvard Crimson and then found herself in Central America, where she had an Inter American Press Association fellowship. She worked for Reuters in New York, Florida and the Caribbean and Washington. As a Kaiser Family Foundation media fellow in 2006-07, she wrote about aging and palliative care. She spent three years writing and blogging about health policy at the nonpartisan New America Foundation.

Her work has appeared in numerous publications including The Atlantic, Kaiser Health News, the Washingtonian, CQ, The Washington Post, the Center for Public Integrity, Health Affairs, AARP’s The Magazine and Bulletin, National Journal, Slate and Miller-McCune. She co-authored two books that have absolutely nothing to do with health: “The Costa Rica Reader” and a parenting book, “The Sleep Lady’s Good Night, Sleep Tight.” One was adopted in college courses. The other one made money.

When she isn’t busy trying to figure out what Congress is up to (not that Congress always knows what Congress is up to), she can be found in Bethesda, Md., with her husband, Ken Cohen, and their two sons. When she needs a break from health policy, she writes about her kids, chocolate cake or cross-dressing female pirates.

Len M. Nichols, PhD, has been the Director of the Center for Health Policy Research and Ethics (CHPRE) and a Professor of Health Policy at George Mason University since March 2010. He has been intimately involved in health reform debates, policy development, and communication with the media and policy makers for 25+ years, after he was Senior Advisor for Health Policy at the Office of Management and Budget (OMB) in the Clinton Administration. Since that time he has testified frequently before Congress and state legislatures, published extensively and spoken to a wide range of hospital associations, hospital systems, physician groups, boards of directors, and health policy leadership forums around the country.
Dan Polsky, PhD, a national leader in the field of health policy and economics, has dedicated his career to exploring how health care is organized, managed, financed, and delivered—especially for low-income people. Raising awareness on social media about the trade-offs between quality of care and total health spending is just one of his many passions.


Diane Rowland, ScD, Executive Vice President at the Foundation, is a nationally recognized health policy expert with a distinguished career in public policy and research focusing on health insurance coverage, access to care, and health financing for low-income, elderly, and disabled populations. From 1991-2016, she served as Executive Director of the Kaiser Commission on Medicaid and the Uninsured, now the Kaiser Program on Medicaid and the Uninsured. Dr. Rowland oversees the Foundation’s health policy analytic work on Medicaid, Medicare, private health Insurance, HIV and global health policy, women’s Health Policy, and disparities. A noted authority on Medicare, Medicaid, and health policy, she testifies frequently and has published widely on these issues.

Chapin White, PhD, is a adjunct senior policy researcher at the RAND Corporation, specializing in health economics, and a Pardee RAND Graduate School faculty member. His work combines quantitative and qualitative methods and focuses on provider payment reform and the implementation and impacts of the Affordable Care Act (ACA).

White is currently leading the development and application of RAND’s Health Care Payment and Delivery Simulation Model (PADSIM), and recently completed an analysis of health reform options for the state of Oregon. In other recent work, White has analyzed the spillover effects of Accountable Care Organizations (ACOs) on the Medicare fee-for-service program, out-of-network hospital care in New Jersey, and alternatives to the “Cadillac” tax using RAND’s COMPARE microsimulation model.
Paul Hughes-Cromwick, MA, CBE (Certified Business Economist), is Co-Director of Altarum’s Sustainable Health Spending Strategies (SHSS), where he has worked for 17 years. He has 35 years of professional experience, spanning academic, private, and government sectors, including the University of Michigan-School of Nursing, Henry Ford Health System, University of Pittsburgh Graduate School of Public Health, State of Connecticut Office of Policy and Management, and the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE). He also has 20 years of experience on health plan and hospital Boards of Directors, including Board Chair of a health insurance plan, and seven years as Chair of the National Association for Business Economics health economics roundtable. He has significant experience in health services research, including cost-effectiveness analysis, and proven successes in strategic planning, business development, outreach including social media, organizing scientific meetings, large grant awards, project management, and establishment of research programs. His research interests are tracking and investigating national health expenditures leading to U.S. cost control and fiscal sustainability, economic analysis of health reform, health insurance studies, health system incentives, and stimulating and financing investments in the social determinants of health. He has multiple publications in a diverse range of journals, presentations in varied contexts, and is widely cited in the media. Since 2011, he has directed the annual SHSS health spending symposium, developed the agenda, and selected and confirmed all presenters. He was instrumental in initiating Altarum’s Sustainable Health Spending Strategies center and developing the initial concept for the Health Sector Economic Indicators℠.

Samantha Clark is a former graduate student intern at Altarum’s Center for Value in Health Care and current master’s student at the University of Michigan School of Public health studying health behavior and health education. She will graduate in May 2020. She earned a bachelor’s degree in health and society at Michigan State University. Before beginning graduate school, she worked for 2 years at the Centers for Disease Control and Prevention in Richmond, Virginia on emergency response preparedness, for 2 years at RTI International in Research Triangle Park, NC, on the 2014 IMPACT Act to improve post-acute care for Medicare recipients and other projects.
SYMPOSIUM AGENDA

With funding from the Robert Wood Johnson Foundation
Altarum Center for Value in Health Care presents

SUSTAINABLE U.S. HEALTH SPENDING: COST CONTROL WITH IMPROVED VALUE?

Tuesday, July 9, 2019
Rayburn House Office Building, 45 Independence Ave., SW, Washington, DC

AGENDA

8:30–9:00  Continental Breakfast and Welcome
Katherine Hempstead, Sr. Advisor to the Executive VP, Robert Wood Johnson Foundation

9:00-9:30  Presentation by Rep. Debbie Dingell (D-Michigan)

9:35–10:20 I. Health Care Spending, Government Budgets and Value
Len Nichols, Professor of Health Policy, George Mason University—Moderator & Envoy
Michael Chernew, Leonard Schaeffer Professor of Health Care Policy, Harvard Medical School
Marc Goldwein, Sr. Vice President and Sr. Policy Director, Committee for a Responsible Federal Budget

10:25–11:45 II. Health Care Spending and Value: New Dimensions
Dan Polsky, Professor, Bloomberg School of Public Health and Carey Business School, Johns Hopkins University
Rena Conti, Assoc. Professor, Markets, Public Policy and Law, Questrom Business School, Boston University
Ziad Haydar, Former Sr. Vice President and Chief Clinical Officer, Ascension Healthcare
Chapin White, Adjunct Senior Policy Researcher, Rand Corporation

11:50–1:10 III. Health Care Spending and Value: Data, Policy, Vulnerable Populations and the Future
Joanne Kenen, Executive Editor, Health Care, POLITICO—Moderator & Provocateur
Niall Brennan, President and CEO, Health Care Cost Institute
Sabrina Corlette, Research Professor, Georgetown University Center on Health Insurance Reforms
Susan Dentzer, Visiting Fellow, Robert J. Margolis Center for Health Policy, Duke University
Diane Rowland, Executive Vice President Emerita, Kaiser Family Foundation

1:10–1:45 Lunch and Informal Discussion
WELCOME AND INTRODUCTION

Katherine Hempstead
Hello everybody. Thanks so much for being here today. This is one of my favorite events of the year, the Sustainable Health Spending Symposium. And this is a great, new location for us! Thank you very much to Congresswoman Dingell’s staff for getting us this excellent room. It is a perfect location. I see many new and old friends and we have a superb agenda today. When I consider the extent to which health care cost has been a consumer issue and something that people are discussing now, I reflect on the importance of the data and research-oriented journalism in informing us and driving the conversation. I see many people here that have made a significant contribution to building knowledge in that area. I look forward to hearing from everyone today. Without further ado, I will welcome the Congresswoman, and again my thanks to all of you.

PRESENTATION BY REP. DEBBIE DINGELL (D-MI)

Rep. Debbie Dingell kicked off the symposium with a speech on the need for action to address problems with our health care system. Please view the conference video to see her presentation.

PANEL I: HEALTH CARE SPENDING, GOVERNMENT BUDGETS AND VALUE
WELCOME AND OVERVIEW

Len Nichols
Thank you to Congresswoman Dingell for an inspirational start to this symposium!

My name is Len Nichols and I will moderate this wonderful session. I especially love the title, “Health Care Spending, Government Budgets and Value.” Value is a wonderful word and you could say it is the point of this whole health enterprise. I want to thank Paul Hughes-Cromwick and his team for putting this amazing conference together for all these years. I highly recommend that you look at the Altarum website regularly. Their Healthcare Value Hub, run adroitly by Lynn Quincy, is a center for all value considerations.
When I think about value, I always remember a quote contained in the Samuelson textbook from which I first learned economics. Remember Oscar Wilde’s quote about a cynic? “A cynic is someone who knows the price of everything and the value of nothing.” That reminds me of an important distinction. Oscar Wilde was a closet economist. He is teaching us that price is not the same thing as value, which is very important to keep in mind. As you know, with economics training we have, of course, two hands. On the one hand, the best thing about economics training is that we are excellent at listing all the possible components of value. Believe it or not, we do consider non-financial value, though few people give us credit for that. We invented the concept of opportunity cost, which is part of fair and outward value. On the other hand, in my view, the worst part of being an economist is that we are over-taught to be reluctant to make normative statements about things such as what should we value and how much should we pay.

Today, we have two eminent thinkers with economics training who will help us navigate this two-pronged approach to value: Mike Chernew, who needs no introduction, is the Leonard Schaeffer Professor of Health Care Policy (of course, Leonard Schaeffer saw value in transitioning something called Blue Cross at the time into WellPoint, which is now Anthem, and did well for himself and, among many other philanthropic activities, endowed Mike’s chair [at Harvard]); and Marc Goldwein, who is a senior vice president. He is probably the youngest senior vice president in Washington and is also senior policy director of the Committee for a Responsible Federal Budget. What a concept! You should give this guy a hand for trying to do that, and we wish him good luck. Mike will discuss value-based purchasing in Medicare, and how we pay for and measure value. Then Marc will discuss the federal budget. Every time I think about the federal budget, I am reminded of my personal hero, Uwe Reinhardt. One of his many famous quotes was, “A budget document is a memo to God about our priorities.” I cannot wait to hear from Marc what our actual priorities are and what we are doing in Washington.

VALUE-BASED PAYMENT

Michael Chernew

It is always a challenge to follow Len as you never know what will be in the introduction. Thank you, Len! I also want to thank Altarum. I have been working with them for years, and they have produced some tremendous information and insights, and it is an honor to be here and talk to all of you.

I was asked to talk about value-based payment, and after the congresswoman’s talk, which I think was very useful in setting the stage, it will be clear what I think is happening. Let me begin with a general point. The reason we are here, in my opinion, is not because of health; we are here because of money.

The challenge, as highlighted by Congresswoman Dingell, is that in many ways, the system tries to care about people, but the policy is running headlong into budget constraints, which Marc will address at length. You may know who these people are (Figure 1), but you likely cannot imagine what Steve Jobs and Sonny and Cher have in common! In any case, health care spending exceeded income growth of the country for many decades. No matter what music you like, health care spending grew more quickly than income and that is mathematically a problem at some point. That is national data, and keep in mind that this spending is a serious problem for the government.

In our national conversation, some people worry about overall spending and are trying to make the system more
efficient. They worry about rising premiums and higher prices, and how we deal with that in the commercial sector. Others are only worried about the federal budget and what the government is spending, for example, on Medicare (Figure 2). Of course, you can save the federal government money by shifting more to the commercial sector, and you can save the commercial sector money by shifting more to the federal government. There are clearly distributional consequences that underlie the financing. Even though I love talking about this aspect, I will refrain today and eagerly wait for Marc’s presentation.

Len spoke about the word value and I will say that it has become a cliché. It is quite difficult to find any health policy article that does not have value in the title: volume-to-value and we need more value because who could oppose value? No one is anti-value! Like apple pie and, with Debbie Dingell here, Chevrolet, it is the same. It seems that the best way to advance any policy is to put value before everything you want to do.

I will emphasize value-based payment in the context of Accountable Care Organizations (ACOs), Medicare episode-based payment, and population-based payment, all of which are aiming to strengthen incentives to providers.

There is also value-based insurance design (V-BID), an issue dear to my heart, which concerns how we set up benefit packages to promote value in care, by giving proper incentives to patients. Please understand—we want people to have access to care, but not all care is good. We want to separate good from bad care and ensure that people do not face financial barriers to accessing high-value care.

There have been notable positive developments with V-BID on Section 2713 of the Affordable Care Act, the Medicare Advantage waiver, and new rules governing Health Savings Accounts. That is the idea behind value-based insurance design, which I promised Mark Fendrick I would mention, but I will not comment further on this.

A third avenue for value-based care is value-based networks. I receive many calls asking for help in building a value-based network, for example, how to get high-value physicians on a network and how to measure it. These patient incentives include narrow networks, tiered networks, reference pricing, and other steerage. This is another great talk that I am not going to give today!

This is, of course, Mary Poppins (Figure 3). My view of the word value in this whole discussion is that it is essentially
the sugar that makes the medicine go down. Instead of a
discussion of value per se, and value-based payment, this
is truly about transferring risk to providers. We have all
manner of quality metrics and HEDIS measures. If you have
significant time in the next month, spend it trying to figure
out the Merit Based Incentive Payment System (MIPS). You
will not succeed. These quality measures enable us to label
all these new payment models as value-enhancing. But the
real bang for the buck here is not about an elaborate new
pay-for-performance system. Rather, it is that we have
decided, for better or worse, that we are going to have
the responsibility to control our spending problems reside
with the provider community writ large, and we are going
to push that risk down to them in many ways. Risk-based
payment through capitation are words you cannot say
(like George Carlin’s Seven Words You Can’t Say on TV).
Capitation is one of those words, but value-based payment
is something everyone can get behind, and that is what we
have done.

A few general thoughts about value before proceeding.
First, I am often in settings where people say that you
should pay more for a better-quality product, but that is
not how economics works. Computers are much better
than when I first met Len, yet as their quality has improved,
the price has gone down, not up. Second, water is an
incredibly valuable commodity. The price is relatively low.
Economics works through innovation and reductions in the
cost of production. The price falls and the organizations,
the stakeholders that capture the value, are the consumers.
In a well-functioning market, the consumers realize that
value. Just because you produced a better product does not
mean you should charge more for it. If the market is working
well, that surplus, be it drugs, or hospital services, would be
captured by the consumers and the reason you would pay
more for value is because you need to induce the production
of more value. You want to induce more innovation and
better quality. That is a rationale, as opposed to wanting to
give the surplus from better value to the producers.

Why are we doing all of this? There are two reasons. First, I
argue that we need a flexible payment system. The problem
with fee-for-service—I am thankful that Bob Berenson
is in the audience, though as my foil, I now feel a little
sheepish—is largely, you can make a system work with lower
fee-for-service payments, but it does not give incentives
for efficiency. If you switch from office visits to e-consults,
if you find a way to avoid an MRI, etcetera, that is not a
financially-winning move. It is difficult to better coordinate
care and financially make it work in a very fragmented fee-
for-service system.

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In a well-functioning market, the
consumers realize that value.

The advantage of a flexible payment model, for example,
a broad population-based payment, is that it allows the
producer to use the inputs (office visits, MRIs, surgeries,
etcetera) in any flexible way to produce the output we care
about, which is health. Too often in health care, we think
the output is the input. We measure output by the number
of hospital days, admissions, surgeries, or the number of
scans. Those are not outputs; they are inputs to our desire
for better health. Efficiency requires the firm to be able to
organize the inputs in a way that is most effective to get
the output at a lower cost. That is hard to make work in a
fee-for-service system. I will give you insights about the
effects of these models in a minute, which are not that
great.

The other reason we are here is that the alternative is a
very low fee-for-service trajectory world. We previously
paid physicians in Medicare via the sustainable growth rate
system that was many things, but definitely not sustainable.
We substituted it with MACRA, a system in which physicians
receive basically no nominal fee increases between now
and forever. This is a very low fee trajectory. Under the
Affordable Care Act, for hospital and facility fees, we
introduced a productivity adjustment where payment is
roughly a percent less than the increased input cost. Nurse
wages rise 3%, the fees go up 2% and the difference is
supposed to be made up by greater productivity, which may
or may not happen. We may be able to deal with this low
trajectory world since we start from a position of very high
prices, but in any case, that is the alternative.
The basic play here is to find a way to allow the people who can produce health more efficiently to capture the savings, and to avoid being in a world in which we balance our books by having lower and lower public fees. That is my general view of what is going on.

What do we know from the research to date?

▲ ACOs save Medicare modest amounts, less than 10%, and by that, I mean about 3%!
  • Physician organizations do better (it is harder for the hospital to retain savings).
  • Commercial ACOs perform better than Medicare ACOs. Part of the reason is that commercial ACOs can generate savings by referring patients to lower-priced providers. That is roughly half of the savings in commercial ACOs. You cannot get those savings in Medicare because the prices are set administratively and are much lower.
  • Post-acute care, for example, skilled nursing facilities (SNFs), are the ATM for ACOs. Everybody wants to save money by reducing utilization of care that is not provided by them. Post-acute care is one area where many are reducing spending and sharing those savings.
  • Many believe that care coordination provides a ready source of savings. You will hear providers say, “We are going to gather all of our diabetics and improve their treatment.” You could call it care coordination or case management. But that is not the source of most of the savings. In fact, if you examine many patients, you will discover new health problems. You will then spend resources treating these diseases. Thus, the way to spend less, is to identify the care you do not want to provide and that largely seems to be post-acute care.

▲ I wrote on my slide that ACOs improve quality because someone will take a picture of it! While I think that is true, more accurately, they do not reduce quality. There is evidence of improvement, but quality is incredibly hard to measure. We have worked with the National Quality Forum. There are hundreds of measures, they all have problems, and then we miss important aspects such as diagnostic accuracy.

▲ Episode-based payment (EBP) also does not impede quality. It saves modest amounts and the effects vary by episode type. The Comprehensive Care for Joint Replacement Model (CJR) was extremely successful.

Incidentally, there is significant post-acute care in joint replacements; not so much for other episodes. We need to also worry about episode expansion. Instead of paying for services, you now pay fees per episode. We have done work showing that this is not a serious problem, although I think more research is needed.

Figure 4 comes from the Alternative Quality Contract, a commercial ACO in Massachusetts. It shows that the first cohorts saved a few percent, but by the end, they were saving about 10%. The central tautology in shared savings models is that the savings get shared. This is not how much the system overall saved because these savings were shared with providers. But by the end, each cohort was saving about 10%, divided roughly in half for prices, and roughly in half for use. They did not make money on net until about four years in.
For some episodes there were significant savings (Figure 5). This comes from the Lewin evaluation of the CMS Bundled Payments for Care Improvement Initiative. While for some episodes the savings were sizable, for others they were limited. If you intend to save money, you need a case theory. Where is the new efficiency, and from where will the savings derive? It is not going to be uniform across all the bundles. For those who read a paper about the large joint replacement savings due to decreased post-acute care (yes, there are other savings in joint replacement), they may think, “Oh my God, episodes are great, let us try it in dermatology.” I have no idea if you could save much in dermatology, but the point is that the process will be different from joints, and especially to the extent that there are no post-acute care savings.

How would I compare episode- and population-based payment?

▲ Both lower spending.
▲ Episodes are narrower, and it is more difficult to generate per member per month savings. You could save 10% on knees for example, but they are a small share of total spending and thus generating systems savings is difficult. You would need to broaden the reach of episodes, which is difficult due to defining them for chronic conditions or dealing with patients who have simultaneous, multiple episodes. It becomes much more challenging as you expand the number of episodes to have them play well together.
▲ Not all areas can support population-based payment. There are difficult questions about how much risk to impose. A significant challenge for the CMS Innovation Center is to determine how to manage the risk trajectory in areas where providers cannot bear risk.
▲ Episodes do a better job of engaging specialists because of their focus on them.

Here is where I think we are going, as opposed to where we should be going (although I do support many of these initiatives):
▲ More risk will be imposed, but care is needed with voluntary programs since with no participation there are no savings.
▲ Better program design in many ways, but mostly on the benchmark used to determine the savings percentage.

Integration of ACOs and EBP, with each other, and with benefit design. On the commercial side, you will see substantial effort to do this.

▲ I believe the savings overall will stem from a lower benchmark trend rather than from quickly realizing shared savings. The basic play that works is to setup the world to become more efficient and establish a budget trajectory that rises more slowly. Let the delivery system live within those constraints and that is the way to generate savings, not “We’re going to induce you to save 10% and we will take a big share of that back.” If you take back much of it, the incentives to generate savings will be limited. That is the fundamental problem.
▲ “Appropriability” is crucial. It is difficult to have the private insurers control the delivery system, because when they get the physicians to change their behavior, their competitors reap some of that savings.

Everything is relative (Figure 6)! We want a nice house. We have a broken system. What we can build is a tiny house. That is the key point. We have not saved much money, perhaps a few percent of Medicare. But be happy we saved any money at all and build on it. Do not look for the next big solution because I doubt we are going to find one. The execution truly matters.
Good morning, everyone. I am going to pull back a bit to a more 50,000-foot view. I run policy at the Committee for a Responsible Federal Budget (CRFB). I previously worked on the Simpson-Bowles Fiscal Commission, the Hensarling-Murray Super Committee, and have a substantial amount of experience failing to fix our fiscal situation! What I want to do this morning is describe the fiscal situation facing the federal government and its relationship to health spending.

Economists like to measure our debt relative to the size of the economy. Think about it this way—if you have a $200,000 mortgage and you are making $2 million a year—it is no problem. However, if you have a $2 million mortgage, and you’re making $20,000 a year, it is a huge problem. Same for the federal government. Debt is not inherently bad, but we can only have so much as a share of the economy before we get into trouble. From that perspective, President Trump entered office with debt at 77% of the GDP—a higher share of the economy than any other president in history except for President Truman (Figure 1). President Truman had a good excuse for the debt. There was the Great Depression and World War II. President Trump also had a decent excuse as we were coming out of the Great Recession. You can see over the course of the Great Recession that debt expanded substantially, which was attributed to people not having jobs and paying taxes as well as considerable spending to try to rescue the economy.

Under Truman, we ran balanced budgets for quite a few years and by the end of the Eisenhower administration, we had brought debt back down to where it had been historically. It only took two presidential administrations to erode all the debt we had built up over World War II. We are facing a very different situation now. If we continue on our current law path, our debt of almost 80% of GDP is headed to reach almost 150% of GDP within 30 years (Figure 2). That is significantly higher than the prior record of just over 100%.

But that is current law, which assumes that the big spending deal we passed a couple of years ago, for defense and nondefense, goes away. We have a $125 billion cut for these spending items scheduled for October 1. It also assumes that the Tax Cuts and Jobs Act will go away (at least for

**Editor’s Note:** On Oct.15, 2018, the U.S. Treasury Department released data on the federal budget deficit for fiscal 2018. It grew to $779 billion, the largest deficit since 2012.
individuals income taxes). If we instead assume those are extended along with delays of Obamacare taxes, etcetera, we have debt headed to over 200% of GDP. That would be twice our historic record. There is only one country in history that has had debt that high and has not either faced a crisis or correction, and that is Japan. Outside of Japan, historically, once countries get above the 150% range, they end up in a crisis or major correction. The good news is that the United States has the strongest economy in the world. We are the world’s reserve currency. While our current economic state is bad, it is not catastrophic.

What is catastrophic is our 75-year outlook. The Congressional Budget Office (CBO) does not make these projections anymore; but CRFB did assuming the economy continues on its current path (with no adverse consequences of mounting debt) and we found that debt would reach about 600% of GDP—six times the economy in 75 years (Figure 3). There is no historic, international, or theoretical basis to suggest that this is possible or sustainable. This is not going to happen. Thus, the big question is, how does it not happen? Does it not happen because we make choices in advance or because we have a crisis? We do not know yet. We know this is unsustainable. Our debt is on a course that literally cannot continue forever.

What are the consequences? Let me start with the textbook economic consequences. This is what I teach in my economics class: crowding out. The consequence of debt is that when the federal government issues bonds, people buy them instead of making productive investments. It does not make a significant impact year-to-year, but over time, that accumulates to less investment in software, equipment, machinery, buildings, and lower wages—lowering the economic growth. Rising debt reduces income per person. In 2049, CBO projections show a $9,000 per person difference in income between whether we “fix” the debt by putting it on a downward path and whether we “break” it by putting it on this upward path (Figure 4). Income could be almost $100,000 per person or could be just over $90,000 per person. That is a huge difference in income, depending on what happens to the debt.

Higher debt equates to higher interest rates on loans for households and businesses. The government will spend more of its revenue on interest payments displacing other priorities and investments. In five years, we will spend more on interest than on defense. In 30 years, interest will be the single largest government program—larger than Medicare and Social Security! There is a generational unfairness with younger and future generations paying the price of today’s consumption. I have a 2-year-old. When she is 17, Social Security will be insolvent. She would get a 20% cut in benefits or $250,000 over her lifetime.

Borrowing is good when we are in a recession, but the higher our debt is entering the recession, the less room (fiscal space) we have both politically and economically to combat that recession. There is a large body of research showing that countries that enter recessions or other crises, such as wars, with high debt are not good at fighting them.

We also have multiple trust funds that are headed towards insolvency. Lastly, there is a small but increasing risk of fiscal crisis. At some point, it could become so bad that either it would spark a financial crisis, or we would print money, leading to an inflation crisis, or we would need to engage in
a deep and abrupt austerity crisis. We do not want to face any of these situations. That is where we are headed because our debt is unsustainable, growing to 600% of GDP.

That is our fiscal situation. What does it have to do with health care? For starters, health care is the single largest part of the federal budget. About a quarter—or $1 of every $4—of federal government spending is on health care. About $1 of every $5 that the government gives in tax breaks is health care-based. Health care comprises a huge share of the overall budget and of our tax code (Figure 5). Outside of interest, it is also by far the fastest growing share. Historically and going forward, you can see that, going back to the late 1960s, health care had a relatively small share of the budget. It is now a very large share, and it is projected to double over the next 30 years. Whereas every other category of the budget is either going to be flat or rising more slowly as a share of GDP (Figure 6), Medicare is projected to double, and Medicaid is projected to grow by 60% as a share of GDP.

Health care is a major driver of our long-term debt because it is rising so much faster than revenue (Figure 7). And the Medicare Part A Hospital Insurance trust fund is six or seven years from insolvency, meaning that, on the horizon, if we do not either raise tax revenues, reduce our Medicare Part A spending or move money around, which may be what we end up doing, all providers would face an across-the-board 11% cut, and we would not able to provide full services in Medicare Part A.

What is driving this? Two factors are key (Figure 8). The first is the aging of the population. That is the key driver to the Social Security cost, but it is also a large driver of rising Medicare costs, and to rising Medicaid cost due to spending on long-term care. About one-third of the cost growth over the next 30 years is because we are getting older. More people are entering these programs, and they are more expensive. The other two-thirds is because per person health care costs are rising faster than the economy. Michael Chernew showed that they have been rising faster than the economy in each of the past five decades. The CBO takes a guess based on our entire history that it is to continue growing faster than the economy. If it does, that will significantly push up our cost growth. There is an interaction: more people entering a program and they are more expensive. We are in trouble!

This is not only a government problem. In fact, rising health care costs and aging are economy-wide issues.
It is worth reiterating that the U.S. spends more on health care than any other developed country (Figure 9). Even as a share of our very large economy, we spend about 50% more than the next highest country, and about double the average. Our public sector, which covers a much smaller share of the population—those over 65, low income, and a smattering elsewhere—is about average, meaning that we spend more on one segment of our population as many countries spend on their entire population. We have very high health care costs, and they are rising quickly, not only in Medicare. In fact, they are rising faster in the private sector than in Medicare.

We have a terrific budget model at CRFB that allows us to understand the impact of various scenarios. We began with a thought experiment—what if we made Medicare Part A solvent, and all other health care costs did not grow faster than the economy? In that case, debt would stabilize at about 100% of GDP (Figure 10). That is not great, but it is much better than where we are headed—to 600%. What if, instead, we held spending constant at the 2010 rate? In that case, debt would have stabilized at its current levels. This tells us that if we could entirely fix our health care spending problem by solving the cost riddle, we could fix the debt problem. Realistically, we have an aging population that will rightly demand more health care. There is no way to realistically solve our dilemma with health care alone, but this should tell us that health care cost control can play a major part in fixing our budget situation, in preventing income loss, high-interest payments, and the risk of fiscal crisis.

So, what do we do to slow health care cost growth? Here are the options:

- Improve incentives to deliver higher-value care more efficiently via:
  - Providers (bundled payments, ACOs, value-based payment, tort reform)
  - Patients (cost sharing reform, managed care, supplemental plan restrictions)
  - Employers (limits to tax preference, incentives for low cost care)
  - Drug companies (weaken monopoly power, promote generics)
- Reduce prices paid to providers, insurers, and for drugs
- Promote competition to get markets to reduce the cost of insurance plans, medical equipment, prescription drugs and biologics, etcetera
Sustainable U.S. Health Spending: Cost Control with Improved Value?

- Rethink who pays and who is subsidized, and by how much (adjust premiums, change age limits)
- Expect less care and slower technological advancement
- Accept rising costs, financed with higher taxes, more borrowing, and/or lower non-health spending

Realistically, we will probably need to do all these things.

Health care costs are likely to continue to grow and we are going to have to spend less elsewhere and raise more taxes to pay for it. But by pursuing cost control, and following the above strategies, we should be able to get a lot more bang for our buck along the way.

We can start by looking at the Medicare policies President Trump put forward in his budget (Figure 11), which are quite similar to those favored by President Obama. They are focused on reducing prices and addressing areas where Medicare is believed to be overpaying for things like post-acute care, bad debts, and site-of-service payments where we should equalize the amount we pay doctors in and outside of hospital settings. There is clearly room within Medicare to adjust and reduce payments in a way that saves the federal government money, and in some cases, improves the incentives to spend more efficiently.

So, what about Medicare for All as a solution? (Figure 12). There is a theory that Medicare for All can significantly help with the cost issue. The theory is two-fold. First, Medicare for All would immediately relieve consumers and businesses of that cost by bringing it onto federal rolls. Second, once the government is in charge, they would have more power and opportunity to reduce the cost economy-wide. The easiest, lowest hanging fruit is administrative cost, which would be lower without a need for profits. Beyond that, they can assert administrative reimbursements, “Let’s pay providers this. Let’s get better prices for drugs.” Then they could “nudge care” (I will not call it rationing) in certain directions to save money. That is what other countries with single payer systems do.

There are certainly opportunities with Medicare for All, but there is a huge cost to the federal government, something like $30 trillion over the next decade on top of the $15 trillion we already spend. Exerting the energy to determine how we will raise that $30 trillion, in my view, is a distraction from exerting that same effort to control cost in the health sector. We could do it with a 25% or 30% payroll tax. There is not much public support for that and it comes with serious economic distortion. We could do it through 50 million different tax increases on the rich, but if you add up all the tax increases Senator Sanders has proposed, they would raise “only” about $15 trillion. It is not easy to find this financing, especially if we are talking about the very generous versions of Medicare for All being discussed.

We could either spend the next 5 or 10 years fighting about taxes and how we will pay for Medicare for All, or we could spend it focusing on how we can improve health at lower cost and incrementally move more towards value-based care. I have a preference, but everyone else can have their own as well, and I look forward to a good discussion on it.

**Editor’s Note:** On August 21, 2019, CRFB released an analysis of the worsening budgetary outlook depicted in CBO’s updated Budget and Economic Outlook.
Len Nichols
Thank you both for the provocative presentations. The drill here is, I will ask questions until the audience does! Mike, I was struck by many things, but I think the most impactful for me was when you explained that consumers are not realizing more value in health care. It does not come to us like it does in other sectors. Why?

Michael Chernew
I think you should ask Chapin White! The prices are high, especially in the drug and the commercial space.

Len Nichols
High relative to?

Michael Chernew
What they would be if competition truly worked. That is the problem. There is an advantage of high prices in certain cases, for example, if you are inducing resources to improve access to care. We are paying more for services, particularly in the commercial sector, than we need to, to induce those resources into providing us with the care that we demand. Consider the famous Anderson, Reinhardt, et al., paper, “It’s The Prices, Stupid.” I think we will see mounting attention paid to the prices that we pay for care. But I emphasize that we should not think there is low-hanging fruit and we can easily slash prices without consequences. We must be willing to accept those changes. The tension is, do we want to live in a fee-for-service world and seek ways to lower the prices, or a world in which we allow flexibility around a broader bundle of services? My plea for any providers in the room is once money gets tight, you want control, and these new payment models facilitate that. In the fee-for-service cutting world, the providers are simply paid less to do the same work.

Len Nichols
We are back to the flexibility point, without it they cannot adjust.

Michael Chernew
Right.

Len Nichols
Marc, I was intrigued with your graphs, especially the impressive and incomprehensible 600% of GDP point, which I had not seen before. How much did the 2017 Tax Cut contribute to our fiscal situation?

Marc Goldwein
Great question. If I was giving a budget presentation, I would have talked not only about the long-term debt, but also the near-term debt. The Tax Cuts and Jobs Act added significantly to the near-term debt. Let me backup. Had Congress in 2014 said, “We are going home and not passing any legislation except for appropriations bills and debt ceiling increases,” the deficit this year would be $400 billion. Instead, the deficit this year will be over $900 billion. About 60% of the deficit is because of legislation passed since 2014. A piece of that was MACRA and another was tax incentives in 2015. But the single largest component was the tax cut, which cost roughly $250 billion just for 2019. There is a theory from conservatives called “starve the beast”—if you cut taxes, that will force spending cuts of a similar magnitude. What do we do three months after the Tax Cuts and Jobs Act? We negotiated a huge spending increase for defense and non-defense, of $200 billion in 2019. If you add $250 billion for tax cuts and the $200 billion spending bill, that means that legislation added in only the last year is responsible for about half of this year’s debt.
Len Nichols

Now, I am thoroughly depressed. Let us turn back to health care quality. Mike, I was also struck that quality has slightly improved, but mostly it has not been harmed by the many value-based experiments, which made me feel better. But the question is, given all the emphasis on the quality metrics that providers are forced to report, should we be happy with the level of quality in our health care system? Are we getting good quality value?

Michael Chernew

There are many things we could do to improve quality. It is not clear that the current programs and metrics get us there. That is a basic problem. The effort we spend, and distraction imposed, trying to measure and manipulate quality measures is much higher than the return we get. I have been working with NQF to find ways to reform the quality measurement system. The nutshell from that whole exercise is that we think of quality as measures, which are the ingredients. There are measure sets; think of them as shopping lists. And there are recipes; think of them as how to bring it all together. An enormous amount of effort is put on new measures. There is not enough time considering the entire measurement system to get us what we need. We should be much less ambitious in what we are trying to measure, for example, quality at the physician level for a procedure to achieve our aim, and much more macro to make sure that, in these new payment models, care is not substandard. Let us develop a measurement system where we could detect that, as opposed to thinking how to pay everybody. There is a quality measurement industry in the world. That is an important thing to do. There are innovations by many people going on in that space. But our current path is not giving us the quality measurement value that we need to support our goals. It is causing substantial distractions in ways that I find frustrating.

Len Nichols

I love the ingredients, shopping list, and recipe. It reminds me of when I re-took up cooking as an older man and found this wonderful magazine, Real Simple. We need that for health care!

Paul Heldman (Heldman Simpson Partners, LLC)

This is a great panel! Marc, given what you said about Congress, since 2014, contributing heavily to rising federal deficits, what do you think are the triggering mechanisms for serious deficit reduction in health care? The only thing I can think of is the [Medicare] trust fund. Are there other mechanisms? You mentioned that benefits would drop 11% once the trust fund is exhausted. Is that written into the law that there is an automatic cut in benefits of that level?

Marc Goldwein

What happens when the Medicare trust fund runs out? Nobody knows exactly. What the law says is that Medicare Part A cannot spend in excess of its revenue plus its trust fund, and the delta we project would be about 11%. The thinking, based on legal research from CRS and others, is they would keep delaying payments to providers. They would pay providers once their money came in. My guess is that would result in many providers not accepting Medicare, a much bigger problem. Having an 11% premium increase would be much simpler than providers refusing to accept Medicare because they are being paid late. As for the triggering mechanism, exhaustion of the trust fund is a possibility. I am worried that, for the broader fiscal situation, there will be a fiscal crisis. I am more optimistic on health care because the triggering mechanism can be people writ large being fed up about health care cost growth, not only what the federal government faces, but elsewhere. If President Trump was a less “controversial” president, I would see a huge policy opening now for health care cost control. I still think we will see legislation on surprise billing and drugs, but the stars—other than that one tiny issue of the president—are aligned for movement on health care cost control. We could see it as soon as this year.

Len Nichols

Wow, an optimistic man!

Sabrina Corlette

What about the cost shift? The concern is that as you cut Medicare, the costs are shifted to the commercial sector.

The lack of competition in health care is a big deal. But even if you could make the industry perfectly competitive, prices would still be very high.
Do you have a sense of what that will cost the federal government in terms of the employer tax exclusion? Is there a tradeoff? As prices rise to 200% or 300% or more of Medicare on the commercial side, does that mean lost revenue for the Treasury?

**Michael Chernew**

The person I cite on cost shifting is Austin Frakt, and his excellent research summary. The academic evidence confirms a cost shift—government cuts do translate into higher commercial payments—but the effect is small, at least directly. There has been considerable consolidation in the commercial sector regardless of Medicare and Medicaid payment rates. This consolidation is problematic. There are many drug innovations causing prices to rise. That plays into the tax exclusion issue in health care, which is a quite controversial topic. Two general themes. First, the lack of competition in health care is a big deal. But even if you could make the industry perfectly competitive, prices would still be very high. Consolidation clearly causes prices to rise, but the price variation is much bigger than that magnitude. Second, we need to consider innovation in the context of high prices and how we are going to deal with that broader question.

**Joyce Frieden (MedPage Today)**

With rising prices and the deficit, what will happen regarding the physician shortage? How do you induce more physicians to come into the market, if you think there is a shortage?

**Michael Chernew**

This is my favorite topic that I have not researched! I hire many people. I teach at Harvard Medical School. It used to be hard to be a doctor. Now, it is super hard. I had 150 students in my class. About half of them want to be doctors. I have never seen more stressed pre-med people. If you want to induce people to become doctors, we seem to have not hit low-enough fees to slow down the incredible demand for med students. We could debate what else they might want to do. My informal and evidence-free theory is that being a lawyer stinks. (I apologize to any lawyers in the audience.) We have not seen any effect on the demand for people becoming doctors. There is a separate, stunningly important question about having enough primary care doctors, and how we consider relative prices with specialists—a big challenge for any price-setting model. But the overall issue of, “no one wants to be a doctor anymore,” seems not to be close to valid. There is a large demand for people getting into med school and I do not see it waning.

**Marc Goldwein**

My short answer is, more medical schools. I agree that we do not have a demand problem.

**Len Nichols**

It is not an aggregate problem, but you heard from Debbie Dingell. We do not have enough mental health. There is clearly a specialization problem.

**Michael Chernew**

And a geographic problem. There are urban and rural issues. This gets to the core question about how the prices are set, and how well you think Medicare is doing. We could discuss the RUC and how they set prices, especially for primary care. We could discuss how providers get paid in rural areas and the supply implications. It is all very complicated. The overall demand for being a physician is very high. The question becomes, how do we think through not only overall prices, but relative prices for different types of services, and incidentally, how to better use non-physicians to provide care. Physician extenders such as nurse practitioners and physician assistants are quite capable of providing many services. The flexible payment models have far greater ability to leverage these providers than a fee-for-service system. My Medicare for All take is that if you trust the government to solve these complicated problems, you always will be able to construct a system that looks great. If you fundamentally believe that government will mess it up, you are giving significant power to an organization you do not trust. A tremendous government that gets all the relative prices right, between specialists and primary care and across the board, will do better in many ways, but do you believe that will happen?

**Stuart Guterman**

For years, we have been looking at the growth in health care spending in both government and the private sector, seemingly trying to find one solution, but there are many solutions. Marc, we need to do all the things on your list, not a little bit of them, but a lot of them. All of them together
Michael Chernew

MedPAC has great work on this relationship between payment and cost. We have policies where we pay a percentage of revenue. For some drugs, you get paid more with a higher price, because you get a percentage of the price. That has been an incredibly challenging political issue to solve, yet we likely agree there are good solutions. It is not rocket science. The same is true with site-neutral payments. There is a bigger question about when we think we know where the low-hanging fruit is, which might be higher from the ground than first appreciated. Part of the reason is the truth that somebody's expense is someone else's revenue. When I was talking to the National Governors Association, many saw health care spending as a tapeworm in the economy (a point made by Congresswoman Dingell; also a Warren Buffett quote). Others see health care spending as a Keynesian stimulus. That tension of recognizing that what is paid is received, and vice versa, complicates the low-hanging fruit notion. Part of the reason why we have the problem is because we are willing to have the problem!

Marc Goldwein

I agree with most of what you said, but I would push back on the idea that the trust fund is a distraction. Post-MACRA, there are few opportunities that force policymakers to talk about health care. The trust fund provides an opportunity to pick this not-so-low-hanging fruit that everybody agrees we should tackle, but they need a reason to say, "We have to solve this." Similarly, on the revenue side, when I talk to Republicans who have taken the no-new-tax pledge (most of them in this body), they often say, “Except for Social Security or except for the highway trust fund because these are dedicated revenue sources.” There is nothing magical about the trust fund, but it simply makes it easier for Congress to deliberate tough, necessary choices.

Michael Chernew

Many of our problems lie outside of the hospital trust fund because of excess spending in other areas. Maybe we need more trust funds!

Mike Miller

I am a health policy and life sciences consultant. As a physician, of course I want to ask a macroeconomic question to Marc. You mentioned that there is a “starve the beast”
For years, we have been looking at the growth in health care spending in both government and the private sector, seemingly trying to find one solution, but there are many solutions.

Marc Goldwein
This is more of a political science question than a macroeconomic question. People who support “starve the beast” believe we need to cut government spending but understand that cuts are unpopular. Instead, they cut taxes, which is popular, and this is expected to force cuts in spending as deficits rise. It turned out with Reagan, and as recently as 2017, that this strategy does not work. The reason is fiscal illusion. Once you are in the environment of borrowing to cut taxes, it is easier to borrow for increased spending. After we cut taxes, we typically follow by increasing spending. We cut taxes in December of 2017 and had a large spending increase in February 2018. It does not mean that, over a long-time horizon, starve the beast might not work to some degree. Lower revenue might translate to an appetite for less future spending, but that is really playing the long game – and there is no guarantee it will pay off. It is fiscally unwise, but also politically, does not seem like a theoretical case for it pans out.

Michael Chernew
There is a significant current debate in the macroeconomic community about interest rates and debt. Part of the challenge is that we have much more tolerance for borrowing since inflation has tracked below where we want it to be, and we have not seen interest rates rise to expected levels. Is there something different about the world that low interest rates and inflation can coexist with massive borrowing? Jason Furman has written on this topic. There is clearly tension about when we might see the problems of big debt manifest themselves. It is not going to be a specific level that once breached, the end is nigh. For example, if we go from 90% to 91%, or from 150% to 151%, then suddenly, the world comes to an end. It is gradual thing, but there is an ongoing intellectual debate about how much debt we can tolerate and what it means in the new world economic order. It is politically easier to borrow more than we might have in the past thought was wise. You do not need to starve the beast because you can continue to borrow. It is not as big a deal as people thought it was.

Len Nichols
We have gone from value to how much debt we can tolerate. I think it is time to take a break!
Elisabeth Rosenthal

I am the editor-in-chief of Kaiser Health News and author of, An American Sickness: How Healthcare Became Big Business and How You Can Take It Back. I trained as an MD and before that, I was with the New York Times for 22 Years. This panel is centered on addressing new dimensions in value. I have been hearing about new dimensions in value for almost 30 years and am hoping we can talk about these new dimensions, because I think we are at a crisis point with cost and value in this country. We may even be past it. Following these 4 presentations, we will have a great discussion.

VOLUME TO VALUE AND THE INVISIBLE GORILLA

Dan Polsky

Good morning everyone. My name is Dan Polsky and I am a professor in the Bloomberg School of Public Health at Johns Hopkins University. I am delighted to be here. Regarding new dimensions in value, I will talk about volume-to-value and the invisible gorilla. I am not sure how many people are familiar with the famous invisible gorilla video. I am not going to show you this video. The video has three people in white shirts and three in black shirts and it instructs you to count the number of basketball passes made among the three in white. At the end of the video, it asks if you saw the gorilla. How many people think they would notice if a gorilla walked through the screen during the video for nine seconds and thumps his chest in the middle of it before walking off? It turns out that if you are focused on counting the number of passes, half of the people do not see the gorilla. I did not see the gorilla! If you have not seen the video, I apologize for spoiling it for you. You are going to be looking for the gorilla, but it is fun to watch anyway. The point is that once you have a solution in mind—you can become so fixated on solving the problem using this one approach—that you miss alternative solutions. I am not here to tell you that I have all new dimensions for value but rather to emphasize that the focus on the transformation of payment and delivery from volume-to-value may keep us from seeing the gorillas that are driving health care spending. I am going to walk through several examples in consideration of three volume-to-value “solutions.” The first concerns payment reform. The move towards value and away from volume is slowly transforming delivery—but how has it changed overall health
care spending? The second is about consumer-directed health plans. While they certainly engage consumers, are the choices they promote ones that are value-based or only about reducing consumption. The last solution is value-based pricing, specifically pertaining to drugs. I think of this as misnomer, more appropriately quality-based pricing. It is a classic misdirection. A value-based health care delivery system may be better, but it is a false solution if our goal is to address health spending growth.

Payment Reform

There has been a huge emphasis recently in payment reform. In the last 10 years, we went from almost nothing to having more than half of all commercial payments to doctors and hospitals flow through value-oriented methods. There are many ways this is being done. Rather than based on traditional fee-for-service, payment is based on factors such as processes of care, achieving certain outcomes for patients, providing superior patient experience and financial accountability.

Since Michael Chernew covered this topic in detail during the first panel, I will go through the evidence quickly. However, when we look at the data for all the things we have tried, the results are meh—not a significant difference in health care spending.

We could identify the dollars somewhere, but much of the value and reductions in spending that we have seen in the ACO program have been through one-sided risk. These programs give providers power and they will opt-in accordingly. Providers only want to gain and the potential to lose illustrates why they dislike programs that are two-sided or shared risk. The latter can work, for example in the Alternative Quality Contract, but it is difficult to impose. In one-sided risk, providers are not penalized when they overspend and exceed the baseline. However, if you include these extra expenditures in the total calculation, you will see that Medicare is not saving much money in these programs.

One-sided risk is really the degree to which providers have more control in dictating this volume-to-value payment system. There is some evidence of improved processes with pay for performance, but no consistent evidence of improved health outcomes. There is also suggestive evidence that payment is not big enough to realize significant changes. Finally, with bundled payment, the evidence is mixed and depends on many factors, including the definition of the episode. It may incentivize episodes, which would bring us back to paying for volume.

The gorillas in this situation are the prices. If we wish to move risk to the providers, they will want to be bigger. As they become bigger, they gain more market power and can negotiate higher prices. There are clearly tradeoffs that we need to keep in mind as we push from volume-to-value. We have larger providers that can demand higher prices and we must consider that as we ponder future solutions (Figure 1).

Consumer-Directed Health Plans

Most of you are familiar with this excellent paper, What does a Deductible Do: The Impact of Cost-Sharing in Healthcare Prices, Quantities, and Spending Dynamics. The main point is that when companies introduce high-deductible health plans, there is a nearly 12 percent reduction in spending. But consumers were unable to detect what is a high-value or low-value reduction. They reduce all spending, including potentially high-value care such as preventative services. The authors also found no evidence that consumers learn how to price shop. As we move towards engaging consumers to consider value, the evidence suggests that the incentives do not connect to value. They only connect to chopping overall spending and utilization.

How do consumers shop? I went to Yelp. If you go to Yelp to shop for hospitals, every comment is about parking or the Wi-Fi. If you want to have a consumer-directed hospital experience, have great parking, excellent Wi-Fi, and don’t put the air-conditioning on too high—which this person really complained about (Figure 2). Forget all our quality metrics for hospitals, just put Wi-Fi in there! We emphasize reducing hospitalizations and re-hospitalizations, but that is simply not what is compelling to the consumers.
Another point about prices using shopping for a TV. I knew how many inches I wanted, and I shopped based on prices. Are we going to shop for health care as we do for TVs on Google? There are amazing websites to compare MRIs (a potentially shoppable service), but how do we know “what size” MRI we want? How do we introduce quality when it comes to MRIs? I think about it like I do for wine. I never want the cheapest wine, so I select the next cheapest. If there is quality in the $100 bottle, it is completely lost on me. Is that how we will shop for health care?

Value-Based Pricing

Value-based pricing has generated quite a discussion, particularly for drugs. This is an umbrella term for manufacturers to link prices for a drug to an assessment of how well it works. More sophisticated versions might provide rebates from drug manufacturers if it failed to work, for example, after 90 days. Companies could also charge different prices for the same drug when it is used to treat different conditions and where it works better, that is, “indication-based pricing.” But this is not value-based but rather quality-based pricing.

A major challenge arises when it comes to drugs that are life-saving in that we do not know how to consider the budget constraint. We could set a price based on the value of your life and then struggle to give it to anyone whose life can be saved. If prices are based on the entire value of life, where do the budget constraints come in? Quality-based pricing for unique products that can save a life gives the power to manufacturers to capture all the “rents” from an innovation. Public policy to provide incentives for innovations should insist that rents from innovations are shared rather than fully captured by producers. Imagine if the polio vaccine was priced at its “full value.” We would be broke paying for it or we would still have a polio epidemic. I do not know the solution—hopefully Rita does.

This is how I think about value-based pricing (Figure 3). When I was in college, I loved the day-old bread—I thought it was a good deal. If I bring home the day-old bread now, my wife will send me back to the store! My budget constraint is a little different than when I was a kid. Old bread is a very low value purchase on my professor salary, but it was an excellent value on my student salary. Another high-value purchase involved the individual who bought the $48 million 1962 Ferrari 250 GTO. He probably came home, and his wife was thrilled, right? That was a high-value purchase for that individual based on his budget constraint, probably the happiest person on his block (perhaps the only person on the block or on his island). However, if we set the price of a new drug at $48 million based on the value for an individual, then people will say, “everyone should get that drug,” and we will quickly run out of money. That is my third gorilla in the room.

To finish, I will tell you all to beware of the false solution. Providers and suppliers are setting the volume-to-value agenda with one-sided risk and consolidation, parking and Wi-Fi, and pricing for quality when life is on the line.
RATIONALIZING DRUG PRICING IN THE U.S.

Rena Conti

Thank you Altarum for putting together this outstanding symposium. We are in the middle of drug pricing reform. I am confident we are about to make real progress and are on the cusp of identifying bold solutions to pricing new drugs in the U.S.

I am an expert on drug pricing. I spend considerable time thinking about the supply and demand of these products, and how the price is set. This market is quite complex; the complexity serves its masters and is intentional, making it is easy to get lost in the weeds. It is also easy for policymakers and others to focus on matters that are not going to move the needle in either helping people gain better access or increase affordability. My goal is to consider the objectives of current federal policy and to get you excited about where we are and where we may be going on policy reform.

First, there are no silver bullets, and we cannot alter affordability without addressing incentives for innovation and vice versa. The argument for policy reform should be based on the health care quadrilemma that incentives for sustained innovation and improved equitable access to drugs that transform people’s lives are a piece, and they have to move together. The debate is largely about the prices and access to new drugs. Ninety percent of all drugs consumed in the U.S. are generic or biosimilar. We pay the lowest prices in the OECD for those drugs. We should not alter those incentives. Instead, we should focus on the pricing of existing drugs where there is limited competition, including most notably, specialty drugs, those that are infused, injected, or otherwise delivered, and the prices accompanying the launch of new products.

Why do we need reform? We live in an incredible era of scientific discovery. We are making significant progress on genetics and cellular therapies. The cost of making this substantial progress is nontrivial and we invest significant public funds to have a labor force that can produce the best science in the world attached to this type of innovation. In other words, most of the labor cost and upfront cost for manufacturing or developing the ideas to manufacture these products are fundamentally born by the American taxpayer.

The other part of drug development is done by the private sector. The economics of drug discovery is long, prone to failure, and very expensive. Most new drugs originate in biotech. They do need to pay back their investors. Does that mean the cost of R&D should be linked to the prices charged for these products when they come to fruition? No. The prices are only related to maximizing revenue for the company bringing the product to the market. Once treatments are available, we should obviously use them to improve people’s health. Yet, the prices of these products are exceptionally high. The average cancer drug is launching at a price that is 5 times the median American household income. You do not need a PhD to know that when the price of a drug is more than the cost of a kid’s college education at a fancy private school, there is a problem.

We spend about 20% of health care dollars on drugs. People ask me all the time what the right level of spending is for drugs and other care. It varies by productivity, both for inputs and outputs. It also varies by disease state and the embodied science. There are therapeutic areas that formerly involved physicians and diagnostics tests, and now people pop a pill to manage their disease or even cure it and move on with their lives. That is the promise of new technology and we expect to see more of this. This view that we should be investing in health care that seeks the most productive use but also the most health from these dollars can fundamentally conflict with physician and hospital culture, and market power that both pharmaceutical companies and these other entities hold.
Spending comprises use and price. While there is some overuse of these products, I would argue there is more of an underuse problem. Why? Because the prices are too high. What we need to do is understand why prices are so high. This is a tightly regulated industry and we should consider the federal activities as setting the rules of the road for both what gets developed, and the charges that are ultimately allowed for these products. What is the proper role of the federal government in this market and how does this interact with prices? We have patents to ensure temporary monopoly that coaxes innovators to innovate against all odds and investors to invest in innovation. That sits atop other private incentives to innovate, which include fame and glory. Patents are very important here. This is much different than in other areas of tech where trade secrets are more important than patents.

First, there are no silver bullets, and we cannot alter affordability without addressing incentives for innovation and vice versa.

The NIH drives basic research. The U.S. Treasury also creates incentives for innovators to innovate, investors to invest, and for us to consume more of these services. The FDA oversees monopoly, exclusivity and ensures the safety and efficacy of new products. There are various HHS programs on access and affordability (discounts, rebates, etcetera) to make sure that the most vulnerable patients, or the ones who have the least willingness to pay, gain access. This includes Medicaid, Medicaid best prices, 340B, and all of the insurance programs that are sitting on top of that. Having this much federal control is a good thing. That means that the Congress, which oversees these agency activities, has the power to change the rules of the road. This includes incentives both to innovate and increase the affordability of these products as they become available.

There are two challenges: affordability and greed. The prices of these products are determined by drug and insurance companies. Many people in the U.S., whether they are seniors or individuals insured under their employer’s insurance, are underinsured for these drugs. They face first dollar requirements to gain access to these therapies. This is true for both the new and old products.

Then there is greed. PhRMA is an industry operating within a capitalist system. It has shareholders to please and quarterly profit marks to meet. But the industry is not a monolith. There are truly innovative companies who care about the affordability of their products. They coexist with those that take advantage of permissiveness to charge crazy high prices for products that do not work, and they act to forestall generic and biosimilar competition indefinitely.

Less commonly appreciated, though explored compellingly by Elisabeth Rosenthal and others, is a diversity of participants that profit from this system including physicians, hospitals, and pharmaceutical benefit managers. How do these institutions profit from the system? They buy low and they sell high! They take advantage of discounts and rebates in the system. They don’t pass those price breaks onto patients or patients. They generate revenue off the high prices of drugs that funds other things.

What should we do? We are in the process of changing the operating rules. The first policies coming down the pike are all about competition. Competition is the great antidote to pharmaceutical company greed and to the practices of other institutions that maintain unholy alliances with the pharmaceutical industry to keep prices high and make money from them.

There are other types of greed. We have heard much about rebate reform in the past several years. I do not know if that will move forward. But key to dealing with greed is having a big stick to wave at these industries that are pricing with impunity. One way to restore rationality is simply to set administrative prices and have global budgets. We can look to Europe for good examples of that. That is what the administration’s IPI program attempts to do. We can also look in our own backyards. There are states (New York, Maryland, Massachusetts) that are pursuing global budgets and price setting boards for new drugs. We already have independent, not-for-profit health economics expertise that can help adjudicate value and identify fair prices for these new products. ICER is one example. There are others. These institutions can be strengthened and relied upon, and I think it is best for them to also stay independent.

We also need to experiment with getting out of the business of paying piecemeal for drugs that transform people’s lives and instead move towards quantity guarantees in exchange for lower prices, for example, what the state of Louisiana is doing with hepatitis C drugs. I am part of that policy team.
Louisiana announced a deal with Gilead to bulk purchase hepatitis C drugs in exchange for unlimited access. They are embarking on an elimination strategy that will provide these products for both the Medicaid and state prison populations. This is transformative and is likely a model for thinking through other ways to purchase products, particularly ones that are curative.

Finally, I hope we see much discussion and movement on increasing access and affordability to patients needing treatment. We should strive to reduce disparities and access to treatment that saves people’s lives. Part of the narrative should be that we should all share in the fruits of the science for which we paid. We should not seek to bankrupt innovative companies largely based in the U.S. that produce so much health, provide good-paying jobs, and wealth for us all. We should seek a new social contact with this industry entailing reasonable prices that ensure access and do not bankrupt individual patients, their families, employers, or payers.

Editor’s note: See this Health Affairs Blog published on July 29, 2019, for more information.

REDUCING PREVENTABLE HOSPITALIZATIONS: TRANSITIONING TO POPULATION HEALTH IN A HEALTH CARE DELIVERY ORGANIZATION

Ziad Haydar

Thank you Altarum for having me today. As the former chief medical officer, I am very proud of my long association with Ascension and am pleased to discuss their “story” of challenges and advancements in improving health equity and reducing overall spending.

Ascension is a faith-based care organization founded by religious women who were committed to helping the poor with a genuine desire and passion to eliminate health care disparities; reduce costs; and advance equity, safety, and care for patient populations. This strategic commitment is translated into a series of annual goals to which we tied executive compensation and held associates and physicians accountable across all 150 hospitals. In fiscal year 2018, Ascension provided nearly $2 billion for the care of persons living in poverty and community benefit.

Ascension is one of the largest Catholic health care organizations in the country, caring for about 2%-3% of the U.S. population, or as many people in the country of Denmark! The system has over 156,000 associates and 34,000 providers working to connect care and deliver services. Our annual goals fall somewhere between the world of policy and management and the actual day-to-day execution of running a large hospital-centric organization.

For Ascension, advocacy and services for those most vulnerable include:

▲ Focus on eliminating preventable disparities in care
▲ Socially just minimum wage
▲ Speaking out against drug price hyperinflation, and in support of 100% access/coverage, Medicaid expansion, and mental and behavioral health reform
▲ Addressing human trafficking through advocacy and service
▲ Ascension Medical Mission at Home, and support of Veterans.

With health equity central to our focus, in 2016, we established a series of goals to improve chronic illness management and cancer care across vulnerable populations. In the beginning, the data sources were insufficient for race and ethnicity identification. Instead, we used Medicaid beneficiary data as a surrogate for vulnerable status and we kept refining our data systems. Our goals included addressing health disparities such as diabetes among the African-American population. We set a threshold to
improve care for all with a special emphasis on vulnerable populations, and we invested significant time and effort into this work.

If you ask NQF, “Give me the measures that I could use to advance health care equity,” you will not get them—we had to create them. After developing our measures, we compared our work with colleagues at Kaiser Permanente and Mayo Clinic and found we were consistent in our methodologies. When focusing on vulnerable populations, you cannot equate improvements among the general population as meaningful change, you must compare your starting baseline for the vulnerable with where you are today. Health care equity is not improved by deteriorating the care of the general population to lower the delta. The emphasis must be placed on improving care for all with a focus on the vulnerable, and if there is significant improvement in health status among the general populations that is added benefit.

Ascension’s results on heart failure exceeded our expectations. What was thought to be a valiant effort and the right thing to do, ended up costing thousands of hospitalizations that did not happen (and massive loss in revenues), but we did not back off. In 2018 and 2019, our goals were set to increase colonoscopy screenings and improving outcomes for heart failure, asthma, and COPD—measured by eliminating preventable hospitalizations (Figure 1). Reducing unnecessary hospitalization is beneficial for those whose health is improved and for organizations genuinely focused on population health, but not for fee-for-service based providers. These efforts have helped to pave the way towards fee-for-value and changing our revenue model.

We discovered that payers are not interested in improving care for one condition (which is totally understandable). We worked with colleagues all over the county, both on the delivery and health plan side, and asked them to teach us how to change our revenue model from fee-for-service to taking on more risk. Sadly, we learned that if you succeed in hitting all of your population health goals, you lose revenue compared to continuing to use a fee-for-service payment model. It is not a zero-sum game, it is a matter of simple math and the numbers do not add up.

In the HBO series Veep, this ridiculous character accuses algebra of being Sharia and he wants to eliminate Muslim math and replace it with American math. We cannot do that!

**FIGURE 1.**

We must accept algebra as we inherited it and accept that in an industry where supply drives demand, we cannot reduce cost without rethinking supply. This does not mean that our country should cavalierly shut down hospitals, but we will have to somehow reduce supply. Indeed, we must meddle with the supply and demand relationship because we witness supply continuously growing.

With eroding hospitalizations and margins, there will be winners and losers and that is okay. Market capitalism will regulate the supply because the losers will be forced to shut down. But look what happens when hospitals decide to shut their doors! Suddenly, the language changes among the forces that are against excessive health care spending and are for economic rationality, by arguing that we are taking critical jobs from the local economy. Having been in this position in a few states, it is difficult, but it is not only about Ascension. It happens to organizations across the country. Michael Dowling has a famous saying that everybody is down on hospitals until you try to shut one down, then everybody is up in arms against you.

We hear how difficult it is to trust consumer choices in regulating health care. I do not know if market capitalism works on its own to regulate health care. I am not a policy expert; I am a physician with an MBA. I do not know how to create the regulatory climate to make market capitalism work better. But in my mind, it is a simple equation—we have too much supply for what we are realizing in low health quality and high costs.
Chapin White

I would like to thank Altarum for inviting me to speak. I think there are very interesting synergies across the talks today. The first panel focused on Medicare, health care spending, the deficit and debt trajectories. That might have concerned you about Medicare spending, but I am not worried. Medicare has spending under control! The Medicare Part A trust fund is projected to go insolvent, but I have news for you. Medicare spending in Part A is very well-controlled. The trustees, CBO, and MedPAC have their eyes on the ball. The U.S. Congress will address this issue by raising taxes or cutting spending.

Despite Marc Goldwein’s chilling comments, I am honestly not worried about Medicare. I will focus instead on the privately insured and private health plans. This is the area about which we should be concerned. It is much harder to get a handle on spending among the privately insured. We do not have a “PrivatePAC” (Private Health Payment Advisory Commission) to monitor this. There is a fortress of secrecy around the financial transactions among the privately insured. It is the opposite of Medicare where we have incredible information systems and all the cards are on the table.

In this talk, I will summarize new research on hospital pricing and then draw out the policy implications. The study, released in May, has a very long official title. I call it the RAND hospital price transparency study (2.0). I encourage you to read it. We looked at the prices paid to hospitals by private health plans. We used all-payer claims databases (APCDs). Self-insured employers contributed their claims data, and we measured the negotiated allowed amounts that private plans were paying hospitals relative to what Medicare would have paid for the same services at the same facilities. We call that a relative price, a percent of Medicare. We included 1,598 hospitals in 25 states. The study was partly funded by the Robert Wood Johnson Foundation (RWJF). RWJF was instrumental in getting this effort off the ground. We are gearing up for another round of the study. We are recruiting more employers, more APCDs, and we want to keep growing this agenda.

We found that on average, private health plans in 2017 were paying 241% of what Medicare would have paid (again same facilities, same services). There was wide variation across states, hospital systems, service lines (especially inpatient versus outpatient), and across hospitals. Figure 1 is a “fun chart” from the public report where we rank states, low to high on their prices relative to Medicare for hospital services. Michigan sits at the very bottom at around 150% of Medicare. Indiana is at the very top, about 300% of Medicare on average.

Let me dig further, though, coincidentally, it is awkward! There is a huge divergence between Michigan and Indiana in their private hospital prices. Indiana hospitals receive double or more on average of what hospitals in Michigan get, all relative to Medicare.

But even within a large multi-hospital system, two neighboring states that are similar in many ways, hospitals located in Indiana receive twice the price of those in Michigan (Figure 2). It is awkward that the system is
Ascension Health! This slide is part of our pre-packaged deck. I did not go out of my way to make this presentation more uncomfortable than it had to be!

Consider competitive markets where suppliers cut their costs to operate as efficiently as possible and their pricing reflects this efficient cost of production. In the hospital space with private health plans, the big picture implication for me is that their pricing does not reflect a functioning, competitive market. That may seem like a provocative claim (I am glad to see nodding heads). With the price variation we observe, suppliers are clearly not cutting costs and having prices determined by efficient production costs. Something else is going on. What is contributing to the pricing patterns that we see in private health plans and their interactions with hospitals?

We finally get to the title of my presentation, “The glitch.” I think there are three components, or legs, to a glitch in our health care financing system:

1. Private health plans have bilateral negotiations with hospitals over prices and networks. Hospitals can refuse to contract with any plan they so choose.
2. Hospitals have total freedom to set their charges (list prices) at whatever level they want. When a patient visits a hospital that is not in their plan’s network, either the patient or the plan is on the hook for full billed charges (uncapped, out-of-network liability). I have heard the quip that billed charges are limited only by the hospital CFO’s imagination. Based on the charges we observe, these are imaginative people!
3. There is widespread “unshoppability” of large chunks of hospital care. I see three types of unshoppable hospital services:
   - Natural monopolies, for example neonatal intensive care units. There is a minimum efficient scale since these must be staffed 24 hours a day by highly specialized personnel. You cannot have a half-a-bassinet NICU on every street corner. Once you hit that minimum efficient scale, the hospital running that NICU will cover a large population area. That is a natural monopoly.
   - Human-made monopolies. This situation happens in metro areas: all the OB-GYNs join into a single practice, which is then bought by a hospital system. That is a human-made monopoly. If all the OB-GYNs consolidate and then become owned by a single hospital, if you are having a baby, you are stuck.
   - Emergencies. Virtually every hospital has an emergency department. People will come through the doors regardless of whether their plan negotiated a contract with that hospital.

Together, this three-legged glitch results in dysfunctional pricing.

For different types of health plans and providers, where do we see all three of these elements? Consider Medicare Advantage plans and primary care physicians. Primary care physicians can engage in bilateral negotiations with Medicare Advantage plans but there is not uncapped, out-of-network liability in Medicare Advantage. Bob Berenson and colleagues have done stellar work describing how out-of-network payments for Medicare Advantage are limited by the Medicare fee-for-service rates. Thus, we do not have leg two (Figure 3). There are also many primary care physicians...
and I think unshoppability is not a concern. With Medicare Advantage and hospitals, there are two of the legs, but there is not the uncapped, out-of-network feature; there is not the three-legged glitch stool (obviously not an ideal phrase!).

Consider private employer-sponsored plans. The primary care physicians engage in negotiations, and there is potentially uncapped, out-of-network liability, but unshoppability is not an issue. We see this glitch pop out with private employer-sponsored plans dealing with hospitals and physicians, such as those in emergency departments and anesthesiologists, specialties where unshoppability is a real concern. When all three of these occur, there is a major price problem. How serious is this glitch? Private health plans pay hospitals over half a trillion dollars per year. Based on the degree of pricing dispersion I see, I estimate that 25%–45% is exploitative, that is, taking advantage of the glitch to drive up prices beyond what we would see in a competitive market. Multiplying 25%–45% of $500 billion, you quickly find hundreds of billions of dollars a year. Even relative to total U.S. health care spending and U.S. GDP, this has a sizeable financial impact.

FIGURE 3.

I have three takeaways. First, I have read interesting commentaries on the role and need for price transparency. Measuring and reporting prices paid by private health plans, by itself, will not fix dysfunctional pricing. Partners Healthcare in Massachusetts is a very high-priced system. The Massachusetts government has released multiple reports on this longstanding, high hospital pricing. I call it “Partners Shrugged.” While knowing the outlines of the price problem does not fix it, I think that putting prices on the table is part of wrapping our arms around the glitch and determining how to address it.

Second, which leg of the glitch stool is most amenable to change? I think it is the uncapped out-of-network liability.

There has been significant attention paid to surprise billing in this congress. Typically, the proposals address out-of-network professionals at an in-network facility. That is a small dollar issue. The much bigger impact of this glitch falls on the hospital side. The American Hospital Association and other hospital associations have argued very strongly against setting limits on payments for out-of-network care. Clearly, this poses direct financial risk to their bottom line. Their opposition signals to me that we are getting close to the heart of the pricing problem.

Third, do not expect patients on their own to fix dysfunctional pricing. You can give them price-shopping tools or employ concierge specialists for phone consultations. However, the dysfunction lies between health plans and hospitals, with policy makers intentionally allowing the glitch to persist. Cranking up deductibles will not fix the glitch, nor will providing more patient-facing price transparency tools. I am very interested to hear questions and feedback from you all.

Do not expect patients on their own to fix dysfunctional pricing... the dysfunction lies between health plans and hospitals, with policy makers intentionally allowing the glitch to persist.
PANEL 2: QUESTIONS AND ANSWERS

Elizabeth Rosenthal

I noticed on the program that I am listed as the rapporteur, but I am more of a provocateur which I saw Joanne Kenen gets to be. I will make a few comments before opening this up to discussion. I love talking with health economists and policy people. Yet, we at Kaiser Health News, and in my previous life at the New York Times, hear how these issues play out on real patients’ lives, and the academic theory, as it trickles down, often falls apart and plays out in ways that one never could imagine.

We have focused on two areas in this panel, hospitals and pharmaceuticals—two high-price issues. Chapin mentioned out-of-network doctors in ERs and anesthesiologists. We hear stories from those delivering a baby at a hospital, and the baby is premature and taken to the NICU, but the NICU doctors are out of network. As clever as the policymakers and economists have been, we reporters are struck by how agile the system is at adapting by finding new ways to make money and loopholes in any new policies.

I was an ER physician practicing in New York in the 1990s when HIV/AIDS was a terrible, rapidly fatal disease. A new drug came onto the market called AZT. It was the first drug that effectively changed this disease from a death sentence within weeks or months to the beginning of making it a treatable, chronic disease. At the time, AZT was priced at $8,000 a year ($650 per month). This is what people now pay for insulin! How did the bar change so much in 25 years to arrive where we are today? Our health care system is a great example of “the road to hell is paved with good intentions.”

We discussed weaknesses of relying on consumer choice. Patients tell us that they looked at their directory and called doctors who told them they are in-network but are not taking patients. As a patient, that means not in network. When I go to a website to book an airline ticket, Delta does not tell me the ticket is $300 but that was two weeks ago, so now I must pay this higher amount! We say patients are not good shoppers and while I do not think consumer choice is the best answer, we first need to give them tools including accurate pricing for lab tests given to the patient and her physician. When my doctor tells me that I need a lab test, he clicks a button to send it to New York-Presbyterian Hospital. This test will cost me $7, but if I went down the street to Quest, I will be charged $600-$700. If we gave people real tools, they might be able to use them at the margins, particularly under high-deductible plans, but they are frustrated. We tell them to be good consumers, they follow our instructions and receive an estimate that the lab test will cost $1,000, only to receive a bill for $8,000. If a contractor did that we would scream fraud, but with health care, we accept the explanation. I want to ask each panelist if, at any level, you think we can design a market smart enough to control prices. Do we need price controls? We have tried many approaches and patients may be getting smarter, but so is the health care market. I am putting you on the spot and realize that this is a controversial question.

Ziad Haydar

As the most ignorant on this topic, I will go first! Payment rates for populations could be the solution and there could be a fixed rate between Indiana and Michigan that would solve the problem Chapin raised. I do not think that the fee-for-service model can work to rationalize these funky numbers that we are witnessing.

Elizabeth Rosenthal

Every other country has decided to do some type of rate setting. I do not know where we will go.

Chapin White

Yes, price controls are necessary. Public utilities, for example, electricity generation and transmission, have strong natural monopoly characteristics. We do not let PEPCO run wild and charge whatever rates they want for electricity. Electricity may not be a fun or exciting industry, but it works and enables the rest of the economy to function. Price regulation follows the features of that industry and market. With the Medicaid and Medicare side of the health care industry, we do price controls and they work to constrain spending growth! MedPAC advises Congress on how to fine-tune the price controls. On the private side, we have done a massive experiment to let private health plans and providers negotiate without price controls and we have seen the results. It is unsustainably expensive.
Dan Polsky

I am a card-carrying economist and my license may be revoked. I will say, “Yes.”

Elizabeth Rosenthal

I cannot let you get away with only that. Please expand.

Dan Polsky

We have tried market-based methods and, as currently constructed, health care in the U.S. is a public/private blend. The assumptions we make in an introductory economics class about how the market functions do not exist in health care. If we rely on this non-existent market to determine price, it will not work. We expect basic economic market results without the required assumptions holding. We need something new and I am all for giving price controls a try.

Rena Conti

It is a common misconception that we do not already pursue administrative pricing in the pharmaceutical space. We do. The federal government sets prices in many ways. In Part B, for drugs that are injected or infused, we use average sales prices, replacing a previous ‘system’ of allowing companies to charge whatever they wanted for these drugs. This was enacted in the Medicare Modernization Act of 2003. Policymakers are now discussing supercharging that through international reference pricing or other methods of price setting. We also have PBMs negotiate in Part D, on behalf of the federal government, using the same tactics (and companies) they use for private plans and their beneficiaries. MedPAC is supporting the introduction of a vendor that would act like a PBM on the Part B side. The only place that we do not have pricing leverage is where there is no competition. This is a problem, but we do have options. One is for policymakers to exercise compulsory licensing rules. These are existing rules. We tend to use them infrequently because of the negative innovation incentives they may set. My point is that we are already setting prices and are exploring the options to do even more. The outstanding questions on setting prices are, what level we will set, what is the process that will be used to set prices, and how will we deal with the tendency for the industry to increase prices over time? We already have inflation penalties on drug prices in Medicaid. Congress is currently considering enacting inflation penalties on drugs covered in Part B and Part D in combination with other policies that would help set launch prices. The administration has come out in support of this, as has MedPAC, so we will see where this goes.

Elizabeth Rosenthal

We control pricing in certain government plans. That does not help someone with private insurance who is asked to pay $100,000 or $200,000 for the newest cancer drug. How do you see that spilling over into the private insurance market?

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There is no cap on what people are being asked to pay [for drugs], particularly in high-deductible plans. It is fundamentally eroding access and people’s ability to afford drugs they need to keep themselves healthy.

unraveling in the hospital market. I do not know about different ownership structures. I believe that prices would be higher if the hospital industry was not dominated by non-profits. Let me point out that physician practices are for profit.

Elizabeth Rosenthal
For both the audience and panel, do you think that the non-profit hospitals are charging as much or more than the for-profits?

Ziad Haydar
The web audience question went beyond for-profit and non-profit. It concerned the delivery structure. Is it hospitals versus physician groups versus payers and employers? The challenge is determining if these constructs are the right ones? Is the current dynamic sufficient to advance U.S. health care? The answer is clearly no. The idea of hospitals, physicians, and payers trying to serve employers is not working. I fundamentally believe there are significant opportunities in the co-op models or different types of partnerships between hospitals, providers, and health plans.

Bob Murray
I was a former executive director of the Maryland Hospital Rate Setting Agency, which should reveal my bias. I think that the health care market is screwed up and that administered pricing systems like Medicare and Medicaid have worked well. You see evidence from states that have had success in containing costs. The rest of the developed world has figured this out with some type of government-administered pricing system. There are many options from setting limits or benchmarks for Medicare payments, which some states are pursuing (North Carolina, Montana, and Oregon). Since many people equate rate regulation with pornography, how about “hardcore” rate-setting like Maryland? Where does one start in that spectrum of options for government-administered limits or price setting?

Chapin White
You do not start by paying hospitals 100% of Medicare rates for their privately-insured. That would be financially disastrous for the hospital industry and for the patients they serve. My sense is that you start roughly where we are but put the price trends on a lower trajectory. Where hospital prices are extremely high, it is more plausible for the trajectory to be flat or even decline in nominal dollars. I was on an email exchange with some folks from Indiana who are trying to develop an actionable strategy to address their hospital prices. It made sense to me that they were starting by demanding that the health plan pay hospitals a percent of Medicare rather than using discounted charges or another formula that is based on their legacy system. Pay a percentage of Medicare, set an upper limit that no hospital can be paid more than 300% of Medicare and then narrow the variation and push the trajectory down. That would work in Indiana. In Michigan, it would be terrible to pay 300% of Medicare to any hospital because we want to keep their payments near where they are currently. It is location-specific. This also ties into the Medicare for all debate and how much it should pay. We have allowed this tremendous range in privately negotiated hospital prices to manifest itself and now we have huge variability across states and metro areas. With Medicare for all, payment cannot be 150% of Medicare for every facility, in every state, right off the bat. With that system, some places would get a huge windfall while others would be ruined. The Medicare prospective payment system in 1983 began with a wide variation in cost across hospitals that gradually converged. That kind of phase-in would need to be contemplated with Medicare for all.

Dan Polsky
We have learned from other policies we have tried that every action has an equal and opposite reaction. We need to experiment and test. To the extent that a key government function is rate regulation, it needs to be nimble and make changes as we learn what does and does not work. As soon
as something works, there will be efforts to subvert it. I like the idea of benchmarking and, tied to what Mike Chernew said earlier, we should impose more risk on providers and counter their resistance by lowering their benchmarks. As we move towards a more controlled system, we must find a way to make it adaptable.

Rena Conti

We need to continue to subsidize unprofitable services that are critical to public health. As we analyze how to cap rates and set inflation factors, we must subsidize the safety net. Hospitals generate revenue from drugs that is supposed to go toward subsidizing the safety net. However, these institutions have discretion over what they call the safety net and do not have to keep inpatient psychiatric beds, emergency rooms, or maternity services open. These are areas where we can agree on subsidization even while we rationalize prices. Moving forward, hospital rate regulation must be contemplated in combination with such subsidies. To do so, we must ask ourselves, “What does a functioning safety net look like in many diverse communities across America and how will we pay for it?”

Dena Puskin

I am with AccuHealth and before that I worked for the federal government for 32 years implementing programs such as telemedicine, and focused on the most vulnerable populations. In our large city markets, primary care physicians and some specialists are beginning to refuse insurance and move to a system without regulation. We can control hospitals, but when rate setting becomes too onerous, there is a large enough market where specialists do not need to participate. This increases the inequitable distribution of providers. What are the unintended consequences of moving to rate setting across the board?

Chapin White

This ties back to Congresswoman Dingell’s example of families struggling to find a child psychiatrist who participates in their plan’s network. The supply is so constrained that child psychiatrists can do better financially by refusing all insurance and treat middle- and high-income patients on a cash basis. I do not know if that is the result of prices for child psychiatrists being set low by Medicaid and Medicare and private plans are piggybacking off that. However, I think it is more of a supply problem as Mike Chernew discussed—the wisdom of rebalancing reimbursement rates to bring more professionals into specialties where there is a supply problem and child psychiatry is one of them. Rate regulation by itself does not drive inequity but the relative rates can be used to encourage more professionals in the undersupplied areas.

Dan Polsky

That is a great point! We have a system that is built for those that have significant resources and we make things up for everybody else. It does not serve the majority of the U.S., only the populations who have money. If we built a system that is aimed to serve a broader segment of the population, some may peel off for boutique or concierge care. That might be a trade-off worth making even though it has its own problems.

Elizabeth Rosenthal

When I was an ER doctor, I was part of the hospital and was paid by the hospital. We have seen this disaggregation of medical care which creates many of these problems.
Joanne Kenen

I am the executive editor for health care at Politico Pulse, and I have been moderating this panel for eight years! I think that today's meeting is one of the most provocative and interesting. With such a wide range of topics, if this was Jeopardy! it would be health-care potpourri. Niall Brennan from the Health Care Cost Institute will talk about prices. Sabrina Corlette from Georgetown is going to discuss surprise medical bills. Susan Dentzer is going to remind us of developments that, I think, many of us have come to take for granted, but we should stop and let ourselves get shocked about again, that is, maternal mortality in America. And Diane Rowland will, of course, talk about Medicaid.

ITS STILL THE PRICES STUPID: OBSERVATIONS ON HEALTH CARE SPENDING IN THE U.S.

Niall Brennan

Good morning everybody. Thank you very much to Altarum for inviting me and to the Robert Wood Johnson Foundation for supporting Altarum and HCCI, and many other folks in the health care space. I will discuss health care prices. There were several references to Uwe this morning, and you have heard the quip, “Good artists borrow, terrible artists steal.” I am stealing my title!

I begin by citing themes that were already expressed today. I came to the States in 1994, and at that stage, people were certain that health care spending had reached completely unsustainable levels and that something had to be done. That was 25 years ago, and we have gone from roughly 13.5% of GDP on health care to careening towards 20% (Figure 1). We are still saying that it is unsustainable. Somebody wrote yesterday that health care spending is not a life-threatening condition. While some people think that it is for the U.S. economy, based on the inaction and lack of progress, clearly it is more of a chronic condition that gets worse and worse as the years go on.

The flip side of spending is employment (Figure 2). It is obvious why it becomes so difficult for us to control health care spending when something is almost 20% of the economy, nationally, and even higher in many cities and towns across the country. Making a meaningful impact in how those dollars are spent will result in significant economic pain and dislocation, and the last time I checked,
nobody enjoys economic pain or dislocation, certainly not elected representatives. The blue line is health care employment, which you can see has risen consistently.

This is how I view health care reform efforts in the United States with the benefit of an embarrassing quarter of a century of experience (Figure 3). It is a circular firing squad, where everybody blames everybody else. Payers blame hospitals, hospitals blame payers, and everybody is beating up on pharma right now, maybe for good reason. Strangely, I do think that Americans are indefatigable when it comes to optimism and creative new ideas or descriptions or pilots to address our health care spending problems. One of the root problems (including the optimism) is that everybody thinks there is a way to make progress in a way that does not hurt them; somebody else will be hurt. ACOs are technically a great idea. Obviously, the way ACOs can work and save money is for physicians to try their hardest to keep people out of hospitals. What is the first thing that hospitals did when ACOs became a reality? They bought every physician practice they could find to dull that phenomenon. Instead, we get excited about quality, patient responsibility, transparency, disruption, innovation, and all these delightful words, because it is easier than saying, “it’s the Prices, Stupid.” Here is a nice photo of Uwe Reinhardt and the famous article (Figure 4).

The earlier presentations were excellent. Chapin’s was among the more recent, so my memory still retains it! I love the idea of a “private PAC.” He alluded to the fortress of secrecy. I will show you numbers and analyses based on the HCCI data holdings where the glass-is-half-full version is that we made good progress on piercing this fortress of secrecy. Beginning in 2011, major national payers came together, agreed to set proprietary differences aside, and pool their data with a trusted nonprofit entity (Figure 5). The unfortunate new reality is that UnitedHealthcare terminated their data-sharing agreement with HCCI. Unless we achieve agreements with other payers to replenish that data, we will be taking a huge step backwards in terms of our ability to understand health care spending and utilization for people with private health insurance coverage. Chapin said that he is not worried about Medicare and I mostly agree, but in any case, Medicare has always been a bedrock of making data available for researchers to understand the health care system. On the private side, we face a serious risk. And note, we do not only analyze this data ourselves at HCCI. We make it available to universities and researchers all over the country. The Congressional Budget Office, MedPAC, actuarial societies, and many others use this data.

That is my plea for help, and I will now move on to data and results. The Annual Health Care Cost and Utilization Report is an HCCI signature product. For calendar year 2017,
health care spending per-person for the privately insured population increased by 4.2%, following a 4.9% increase for calendar year 2016. I was struck by the promo materials for this event where they referred to “only” 3.9% health spending growth, and how great that was. Nonetheless, that is still roughly twice the rate of the Consumer Price Index (CPI) growth! Other results from this report include:

▲ In 2017, per-person spending reached a new all-time high of $5,641. This total includes amounts paid for medical and pharmacy claims; drug spending reflects discounts from wholesale/list prices but not manufacturer rebates.

▲ The overall use of health care changes very little over the 2013 to 2017 period, declining 0.2%. In 2017, utilization grew 0.5% compared to 2016.

▲ Out-of-pocket spending per-person increased 2.6% in 2017. The growth was slower than total spending, so OOP costs made up a smaller share of spending by 2017.

▲ Prices increased 3.6% in 2017. Year-over-year price growth decelerated throughout the five-year period, rising 4.8% between 2013 and 2014 and slowing to 3.6% in 2016 and 2017, reflecting slowed growth of drug prices.

Over a five-year period, from 2013 to 2017, total spending grew by 16.7%, which obviously varied according to whether it was hospital inpatient, hospital outpatient, ambulatory care, or prescription drug spending (on the right side of Figure 6). The left-hand side illustrates that this spending growth is predominantly price-driven. Other presentations today have built to this unavoidable conclusion that every year, Americans use approximately the same amount or less of health care, and they pay more for it. Utilization is shown on the bottom of the left-hand chart, and prices are at the top. Take the hospital industry for example (the red line). Spending only grew by 9% over a five-year period, but this was at a time when hospital utilization went way down. Health care is literally the only part of the American economy where you can lose market share and increase revenue. Can you imagine if sales of Nike shoes went down by 10% or 20%, and Nike said, “No problem. We’re just going to jack-up the prices on running shoes and continue to grow our revenue”? That is what happens every single day across the health care system!

Interestingly, out-of-pocket spending is growing at a slightly lower rate than overall spending (Figure 7). You can argue over the rights or wrongs of this, but the payer burden of what we spend on health care is increasing. That said, it is not that consumers are getting away scot-free. This only represents dollars spent on health care utilization; it does not show increasing premiums, declining benefit packages,
the spread of consumer-directed health plans, etcetera.

A note of realism—this story is genuinely complicated. I am presenting macro-level statistics on a population of 43 million people with employer-sponsored coverage, but health care is very granular and different, and you can see that, for 2016 and 2017, there were areas of health care spending that declined and some that rose significantly (Figure 8). We must be careful about crude, one-size-fits-all approaches to these spending issues.

Figure 9 is one of my favorites. It represents a pushback against value-based care. All the value-based care in the world will not save us if prices on the residual services that are still provided are increasing so quickly that, not only are we not making progress, we are sinking even deeper into the financial mires. The right-hand side shows that emergency room (ER) utilization was flat; people are visiting ERs at the same rate. This is a tale of ER facility-fee pricing, of which I had never heard before I came to HCCI. They are the price of admission and are structured exactly like physician evaluation and management (E&M) visits, from least to most severe. Consider rational economic behavior. When you say to somebody, “I could pay you $10 or $50 for this, depending on what code you put on a piece of paper,” you might speculate that Americans magically got sicker as they presented to the ER, or you could believe that there were coding changes. Over time, there was a massive resorting. Overall ER utilization was flat, but many more ER visits were coded as a high-severity. At the same time, prices on those high-severity ER visits—and when I say prices, I mean negotiated rates between payers and providers, not charges—increased by over 100%. It is only one little slice of the health care system, but how can anybody with a straight face say that they are committed to value-based care on the one hand, and be increasing prices for a specific part of that care by 100% to 120% over a nine-year period?

I will discuss next the Healthy Marketplace Index, generously funded by the Robert Wood Johnson Foundation. We took 1.2 billion claims across 112 metropolitan areas in the U.S. employer-sponsored population and defined standardized inpatient, outpatient, and physician market baskets, to create both the cost and utilization indexes that gets us apples-to-apples comparisons. Whenever you profile spending changes everybody has an excuse for why something happens, so we set up this analysis to minimize the number of excuses! Figure 10 shows an overall inpatient market basket where there is massive variation in the prices, ranging from very low in Knoxville, TN, and in other southern states, to very high in San Francisco and Alaska. I get it—San Francisco and Alaska are special health care markets, but we must ask ourselves, “How much variation is acceptable?”
For both inpatient and outpatient services we dove deeper. Figure 11 shows variation in prices for C-sections, both nationally and within individual markets. You can see that prices range from as low as $4,000 to over $20,000. This is not comparing Medicare to Medicaid, or Medicaid to an employer-sponsored population. Everybody in this sample has employer-sponsored coverage. At the bottom right-hand part of the graph you can see the massive price variation in San Diego and San Francisco for the same service for, essentially, the same population. This is after we eliminated the bottom and top 10th of the distribution to rule out that these findings are driven by outliers.

It is the same story on the outpatient side. Figure 12 shows lab tests. Margot Sanger-Katz picked this up in the New York Times. A CBC can range in price from $10 to $1,000 depending on where you live in America, and whether it is done at a Quest facility or at a hospital.

The bottom line is that prices grew rapidly everywhere (Figure 13). You can be in a low-cost or a low-price area, but your prices can still grow very quickly. The left-hand side shows inpatient care, the right-hand side shows outpatient care. Regardless of whether you are in a high-cost or low-cost area to begin with in 2012, prices skyrocketed.

I circle back to the notion of people using less health care but paying more for it every year (Figure 14). The top half shows inpatient price increases in these 112 metropolitan areas; the bottom half shows that utilization was almost uniformly down in each one of these areas.

We have much more information on our website, and I urge people to explore and learn from it.
SURPRISE MEDICAL BILLS: A SYMPTOM OF MARKET FAILURE AND POSSIBLE POLICY SOLUTIONS

Sabrina Corlette

Thank you, Altarum, for inviting me. I am with Georgetown University’s Center on Health Insurance Reforms, at the McCourt School of Public Policy. We study private health insurance. Most of us are recovering lawyers. I am not an economist. In fact, I went to law school, because there is no math on the LSAT. When I was invited to be here, I questioned, “What can I possibly contribute?” Amidst this talk of fiscal and economic doom and gloom that comes with any conference on health care spending, I am hoping to inject hope and optimism on the policy issues surrounding surprise medical bills. They have garnered bipartisan support in Washington and also at the state level, and they are a symptom of a larger market failure or, as Chapin stated, the “three-legged glitch.”

The broad recognition of market failure, especially in terms of the private market not working, has initiated bipartisan attention and support. There is a normal dynamic where providers and payers negotiate over volume and price. The provider agrees to give the payer a discount in exchange for increased patient volume. For some providers, their revenue is not garnered from insurers. Rather, for an anesthesiologist or ER doctor, it is their connection to a hospital facility. The health plan they contract with is less a driver of their patient volume than who walks through the hospital door. This reduces their incentive to be an in-network provider. There are no regulatory constraints on their out-of-network charges, which can be much greater than Medicare rates. One study found that out-of-network ER doctors charge, on average, 800% of Medicare for their services, compared to their counterparts who are in-network, who charge roughly 300%. If the payer does not pay that charge in full, the patient gets the bill. As Elisabeth Rosenthal and her colleagues at Kaiser Health News have documented, those charges can be financially ruinous for many patients.

This bipartisan issue has gained traction as one about fundamental fairness. In many settings, patients are in no position to make informed choices over what provider they see, and there is little transparency. In an emergency setting, you may be transported in an out-of-network ambulance or to an out-of-network hospital. Another scenario is that you have done your due-diligence research and found an in-network hospital and surgeon, but you are seen by an out-of-network physician at the hospital, for example, the anesthesiologist or radiologist. Studies have shown that this is affecting 20% to 30% of the privately insured, and departments of insurance around the country report that this is a top source of consumer complaints. This explains why we have seen White House events calling for action. There are bipartisan bills in both chambers. We may see a senate bill on the floor this month. The Energy and Commerce Committee is expected to mark up a bill soon. There is also much activity at the state level, especially on insurance and provider regulation. We have seen five bills enacted at the state level in 2019 alone.

There is broad consensus that the patient should be held harmless or at least held to in-network cost sharing when they are in an emergency setting or visiting an in-network facility. Yet, there is a lack of consensus on how to resolve these payment disputes between the out-of-network provider and the payer. This is portrayed in both the media and a number of congressional hearings. The controversy is whether we need a payment standard (rate setting by the government) that caps the amount paid for out-of-network services, or, as the preferred approach by the provider community, do we need to establish a prescribed dispute process such as a baseball-style arbitration where a third-
party independent arbitrator would choose between the final offers of either party.

Thirteen states have enacted comprehensive protections, meaning they have taken the consumer out of the equation, held them harmless and set up a structure or system to resolve payment disputes across all payers (for example, HMOs and PPOs), and over a range of health care settings. This does not play out as just a payment standard or arbitration system, it is more complicated than that. A “payment standard state” might have a clear, well-defined method, that is, a percentage of Medicare or an average in-network rate. They might have a less specific standard like “fair and reasonable” or “usual, customary and reasonable (UCR).” They may also specify exceptions to resolve disputes, allow for geographic variation in costs, consider an unusually complex case, or a physician’s unique expertise. States that have a prescribed dispute resolution standard may use it as a primary mechanism for resolving differences between the out-of-network charge and what the plan is willing to pay; in other states it is a back-up mechanism that can be used only after the provider has received a preliminary minimum payment from the payer. Unfortunately, there is little evidence about what is working at the state level as many of these laws are new.

At Georgetown, we analyzed New York’s law. In 2014, they became the first state to use baseball-style arbitration. With the support of the Robert Wood Johnson Foundation and Altarum, this spring we conducted a qualitative case study to assess how this law is working in practice. We found that there has been a dramatic decline in consumer complaints and consumers struggling with surprise medical billing in the settings they were regulating, which were emergency in-network facilities and out-of-network physicians. The insurance companies and providers with whom we spoke consider the arbitration process to be fair, and they resolved the vast majority of disputes before an arbitrator had to be involved.

However, there were gaps. The biggest was the federal law called ERISA, which preempts the State of New York from extending this arbitration regime to self-funded employer plans. Such plans cover 61% of people nationwide. This is where we clearly need federal action. The other big problem that the New York law did not address was the inaccurate and out-of-date information regarding a provider’s network status. This is a significant problem, whether it is the inaccurate provider directory or when members are told that a provider takes “Blue Cross,” but the provider fails to specify that they only take “Blue Cross 500” and not “Blue Cross 1600.” This is a challenge and consumers are caught up in it. We also heard concerns that New York’s approach would have inflationary effects. Instead of reaching the goal of constraining what providers are charging in out-of-network settings, it could give them incentives to boost rates. From either providers, payers, or regulators, we did not hear that this happening, which is not to say that this incentive does not exist, or that this behavior will not play out over the longer term.

Looking at what is happening at the federal level, I am optimistic that there is a way forward. This could mean that payers would be required to pay the provider a prompt minimum payment with the level set by the government through a percentage of Medicare or in-network average. We may choose to have a dispute resolution or arbitration process as a backstop if a provider feels they deserve to be paid more or there are unique circumstances. I am hopeful we will see legislation soon—it seems the stars are aligned in this way.
Good afternoon everybody. It is great to be with you. What I will present is an index case of much of what you are hearing about today. Niall Brennan, I dare say, I will add an entry to your list of ridiculous things that Americans have tried—to engender improvement in health care and reduce spending, but what else is our alternative, except to keep working? As Joanne Kenen mentioned, we have heard much about maternal mortality, and frankly, it is the tip of a very ugly iceberg. This is not a presentation about maternal mortality, but rather what to do to improve the overall birth experience, the outcomes, and the cost in this country.

Based on an amazing ability to grasp the obvious, we believe there are vital opportunities to improve maternal and infant health, nationally, obviously, but specifically, because of Duke’s hard work to put those pieces in place in North Carolina. There are significant successes across the country demonstrating that much can be done if you have collective action across the entire health care system. Actions are needed by public health, public (Medicaid) and private payers, federal, state and local policy makers, nonprofit organizations, social service groups, and the advocacy community. We believe the evidence shows that there is a major role for value-based payment and delivery system reforms via creation of new care pathways and aligned payment models to drive change.

We know there is a rising trend in pregnancy-related mortality in the United States (Figure 1). These data only extend through 2014, but the numbers do not look much better on a preliminary basis after 2014. For every woman in America who dies around the pregnancy experience (about 600 deaths nationally per year), there are multiple more cases of severe maternal morbidity (Figure 2). These are women who almost die for various reasons, including from blood transfusions, preeclampsia, and other factors. This is where much of the pain, suffering, and cost comes in, even more so than maternal mortality. I think it was Uwe Reinhardt who said, “The ultimate economy is death.” Maternal mortality does not cost that much, but severe maternal morbidity does.
Our maternal death rate, per 100,000 live births, is the worst among the developed countries (Figure 3). The causes of pregnancy-related deaths are quite disparate (Figure 4). This problem, of course, is mirrored on the infant’s side. Neonatal mortality, although declining mercifully over the last decade-plus, is still high, especially compared to other countries (Figure 5).

There are mortality disparities geographically, particularly rural versus urban (Figure 6). Behind these numbers and statistics are many people. One of my favorite phrases is, “Statistics are human beings with the tears washed away.” When we do wash away those tears, we can see stories of people like Shalon Irving. Try to wrap your brain around this. Shalon was a 36-year old epidemiologist at the CDC. In 2017, she died from postpartum preeclampsia three weeks after giving birth to her daughter Soleil. Nobody knew she was in trouble. If an epidemiologist from the CDC can die from this, you know that we have a problem in this country.

The situation is better in North Carolina than the worst areas of the country, but not by much, and maternal mortality has been tracking the rising national average (Figure 7). There are large disparities, mainly racial, inherent in these maternal mortality rates, and, of course, there are also age-related disparities (Figure 8). The age at which women give birth for the first time is rising, and that is reflected by the age at which women continue to have pregnancies.

Nationally, obstetric procedures and infant and neonatal intensive care units (NICU), are among the most expensive services provided (Figure 9). It is fascinating how little is known about spending for pregnant women, especially the commercially insured, other than it is expensive. The cost components and the prices remain a mystery. Many aspects of routine maternity care have little supporting evidence. Another interesting phenomenon, echoing the coding example used by Niall, is that there is an increasing tendency to admit infants into the NICU with ever lower thresholds of concern, because the NICU is a large source of hospital revenue.

How to deal with this mess? We surmised that what is needed is to develop more astute care pathways tailored to the risk profiles of women, and to better match them with appropriate health care personnel, new payment models, and patient choice to drive improved care outcomes. We need to make them more aware of alternatives, for example, in what is known as physiologic birth, as opposed to a highly-medicalized birth. Very many women with normal pregnancies could deliver in birth centers with nurse midwives, and do not need to be hospitalized. Certainly, many of them do not need C-sections. The rate of unnecessary C-sections in this country, although having declined, remains extraordinarily high.
There are many state-based opportunities for transformation in North Carolina that build on forces already underway. My Duke-Margolis colleagues, Mark McClellan, et al., wrote about this in a Health Affairs Blog in February. Much is happening. Medicaid is moving to Medicaid accountable care organizations, with a specific effort to address social determinant factors. A new set of Healthy Opportunities Pilots directs Medicaid recipients to social and community services that will, in theory, help to improve health care outcomes and reduce cost.

Transformation is also occurring with Medicare in the state, but I want to flag the reform regarding commercial payment. Some of Centers for Medicare & Medicaid Services (CMS) and Center for Medicare & Medicaid Innovation (CMMI) has relocated to North Carolina! Patrick Conway, formerly the CMMI director, heads Blue Cross and Blue Shield of North Carolina. Mandy Cohen, also formerly of CMS, is now the state Health Secretary. There is significant discussion about big changes with the private payment models. In fact, Blue Cross and Blue Shield of North Carolina has struck an agreement with five of the major health systems in North Carolina to move entirely to value-based payment within the next five years. The rather audacious goal aims to achieve 0% trend growth in the state over a five-year period. Successful or not, those payment arrangements will necessitate care delivery reform. These private, Medicaid, and Medicare reforms have substantial momentum behind them. Employers are also at their wits’ end. Health care costs in the State of North Carolina are sufficiently high that the state now feels that they are a barrier to attracting new businesses. Employers are getting on board with these reforms.

What should we do? Those of you who are familiar with the work of the Health Care Payment Learning and Action Network will know that there was much thought given to creating maternity care payment bundles. They did good work but there has been almost no take-up, and throughout the country, you see states barely tinkering with new payment models. Arkansas has an episode-based model that for me is lightweight relative to what is needed. Focusing on the top of this pyramid, we should consider population-level payments that will be structured around a new set of care pathways (Figure 10). Frankly, we need to start with preconception health and health care for adolescent girls to counsel and guide them through the heavy-duty thinking of how they want to live their reproductive lives. We need to get to the issue of pregnancy intendedness since roughly 45% of first-time pregnancies are unintended. That does not mean that they are unwanted, but they are unintended, which connects with issues of family planning adequacy.

We can begin there and then move through a normal pregnancy experience. We must consider new ways to deliver that care. If you are a low-income woman working
at a low-wage job in a state like North Carolina, and you need to have a monthly maternity visit, you must take a day off for that visit and give up a day of wages. This is all so that you can have sophisticated procedures like giving a urine sample and having your abdomen measured! There is probably a better way to operate that is structured around the patient and not around the needs of the provider system; for example, sending community health workers into neighborhoods or sponsoring telehealth visits. Centering—organizing group visits for care—is very popular, but it still requires people to go someplace. How about a centering visit over Skype? There is significant opportunity to innovate, but unfortunately, little incentive currently. We believe in walking through this comprehensive set of elements, whether it is technology, the personnel, the care that is provided, etcetera. We should assemble this into a package that includes postpartum care for a woman that extends to the infant’s 5th birthday, because about half of maternal deaths occur outside the six-week postpartum window. Women who have high blood pressure and preeclampsia, die not only three weeks after birth, as Shalon did, but six months after. Unless the whole system pays attention to the woman and the baby, as if they belong to each other, we will not accomplish the goals of improving care. Creating this new payment model that oversees the set of processes as a dyad is key.

We have also learned that designing these payment models from the top down and imposing them on providers is a bad idea. It is much better to engage providers in building these models from the bottom up, and that is what we are doing now both on the provider and payment sides. In a state like North Carolina, that means getting people into the room to talk about what they do, what they could do, where the evidence points, and what is possible. It means analyzing the building blocks of care that are available in a state as diverse as North Carolina. It is one thing to consider interventions in the highly-urbanized population of Raleigh, but quite another to do it in the western part of the state, where two rural hospitals recently closed their labor and delivery units, because last year, 30% of the deliveries took place in the emergency department with no doctor present. One of the hospitals could not even get a pediatrician to come to the hospital to look after newborns. The capability of the system to rise to meet these challenges is truly compromised. We have third world health care in large parts of the United States, especially when it comes to the maternity setting.

We are committed to building from the ground up and dealing with this complexity and variation in the local context that we think is so pervasive. Unbelievably, there are only 345 free standing birth centers in the entire U.S., and only four left in North Carolina. We need to develop a new model that builds capacity that is not hospital-based, and that is not designed to get women in the door, patients locked into a system, and then getting their infants into a NICU.

The recommendations that our group is following are to:

- **Build on progress to date, tailored to the local context**
- **Provide the right care for the right patients, bring patients into the equation and have user-centered design where we engage women, and involve families and fathers in how to design these kinds of new pathways**
- **Maintain the maternal-infant dyad and the family context**
Advance collaborative action. We have great enthusiasm on the part of Mandy Cohen at the state health department, and the Medicaid MCO’s, and Blue Cross are on board. The employers are increasingly committed and realize that they have an important stake. Fortunately, we have many factors already in place. Some of you know of Community Care of North Carolina, an entity doing significant Medicaid work in the state for many years. They built a pregnancy medical home model that we think we can continue to refine and build upon. I look forward to any questions or comments.

Joanne Kenen
I was at the CDC a week ago with the Kaiser Family Foundation. We were discussing maternal mortality, and they began with Shalon’s story. I did not know her or the full story but heard that she was not feeling well. She called a doctor and did not get an appointment.

EDITOR’S NOTE: Please see this news item for an update on maternity care payment bundling.

SUSTAINING HEALTH CARE FOR VULNERABLE POPULATIONS

Diane Rowland
We have far too many horror stories in our health care system. To piggyback off Susan Dentzer’s point, consider non-expansion Medicaid states. Many women only get 60 days of postpartum care. Often, they do not get access to physicians that they need. Even if a state chooses not to expand for the male population, they should at least do so for pregnant women, so that they receive a minimum of a year of Medicaid assistance after delivery.

As Joanne Kenen presumed, I will indeed discuss Medicaid. In such meetings, we often talk about Medicaid as a budget item how much it is growing and how much it costs. Paul Hughes-Cromwick said to me, “If we are going to talk about sustaining care for vulnerable populations, we should talk about what Medicaid does, besides contributing to federal and state budgets and potential deficits.” We have discussed several Medicaid issues, but I believe it is important to start by referencing Medicaid as an entitlement. Eligible individuals are entitled to a defined set of benefits and states are entitled to federal matching funds. This federal/state partnership has the former setting core requirements on eligibility and benefits, and the latter having flexibility to administer the program within federal guidelines.

Clearly, this can create budget problems, but it is why, when we need to care for new populations such as those affected by the opioid crisis confronting our country, or why when enrollment grows, states can get additional funding (especially during recessions), that having an entitlement is critically important. Some favor converting Medicaid to a block grant. This would neither be an entitlement to individuals nor the same kind of entitlement to states. In these debates about state flexibility, we forget that states have an entitlement to those funds.

What does Medicaid spending do? It often gets compared to a typical health insurance program or Medicare. However, Medicaid is much more than a health insurer. Many of the people that it ensures have severe and permanent disabilities. Their health care needs are way out of line with those that are covered by commercial and employer-based insurance. One of my former colleagues likes to say, “Medicaid pulls some of the sickest people out of the private insurance risk pool and allows that risk pool to be more affordable for the populations that it serves.”

I also like to remind people that many low-income individuals
on Medicare depend on Medicaid to make their Medicare benefits work (a different take on the motto, Medicare for All!); not only via long-term care services and supports, but by providing relief from Medicare premiums and cost sharing. More generally, Medicaid provides:

- Health insurance coverage for 1 in 5 Americans
- Assistance to 10 million Medicare beneficiaries
- 50% of long-term care financing
- Support for the health care system and safety-net
- State capacity to address health challenges.

We talk about Medicaid as a one-size-fits-all program, but Medicaid is different in every state. It is built around a federal framework that sets core requirements on eligibility, benefits, delivery systems/provider payments, premiums, and cost-sharing, but it also enables waivers. States have the flexibility to administer the program within federal guidelines, and significant choice in their Medicaid program spending. The federal government has rules about who they cover and options for benefit coverage, yet most payment issues are driven by states. People argue that Medicaid does not pay physicians well, but this is a state’s choice, and it reflects on the argument of how much of this program should go federal versus how much remains for the states. Increasingly, the states have moved to put more of their population, especially families, into managed care, where they negotiate rates. They are trying to find better ways to deliver care.

The sustainability of Medicaid will never be based on what it does as a health insurer and how it covers that large segment of children and adults that make up its enrollees. Sixty-one percent of Medicaid’s spending goes to people with disabilities and to fill in the gaps in Medicare for the elderly population (Figure 1). To make Medicaid more sustainable, we must determine how to provide the long-term services and supports this country needs as its population ages, and as more people demand community-based services.

Much of what drives Medicaid is not that it spends too much per person, but that its spending is highly influenced by enrollment growth. Enrollment and spending growth peak during economic downturns and it also peaked with the implementation of the ACA (Figure 2). Growth is highest during a recession, and then it declines.

For FY 2019, states have told us that they are projecting decreased enrollment growth due to a stable economy, processing delayed eligibility re-determinations, and new eligibility systems. In contrast, they expect increased spending growth, partly as a catch-up given their strong economic position, with targeted provider rate increases and efforts to innovate across payment policies. Their main struggle is with higher costs due to a changing enrollment case-mix, and the rising cost of prescription drugs (for example, hepatitis C treatments, as Rena Conti described with the innovative Louisiana program), and long-term care.

The major difference across the country concerns the states that have expanded versus those that have not. Thirty-seven states have adopted Medicaid expansion as of this
year (Figure 3). Thanks to good work by health services researchers and economists, we have solid research on the expansion impacts. Perhaps most importantly, Medicaid expansion enables states to create a more sustainable health care system. There has been a debate over whether longer waiting lists have occurred for people with disabilities in expansion states, but the data has proven this to be false. There has also been significant debate on whether expansion states would go bankrupt. This also appears to be wrong. We are quite proud to have found over 200 research articles that were done mostly at the state, but some at the national level, documenting the impact of Medicaid expansion (Figure 4).

Going forward, we must continue to invest in research to assess the impact expansion has on many variables, including rural hospitals. We know that Medicaid will always be shaped by differences across states in terms of their revenues, their commitment to expansion, the populations they choose to serve, etcetera (Figure 5). As many like to say, it will continue to be the laboratory for studying options on how to serve different populations.

In listening to the Medicare for All debate, which includes proposals to fold the entire Medicaid program into Medicare, I believe we need to find the right balance between meeting the health care needs of the most vulnerable Americans and how to sustain the financing for their care over time. This cavalier view of dismantling Medicaid brings me back to 1990, when Kaiser was first establishing the Commission on the Future of Medicaid. One of the tasks Drew Altman gave me was to talk to politicians about whether such a commission would be useful. It is easy to forget that back in the early 1990’s, Medicaid was not heavily discussed, it was the silent program. The focus was on researching the Medicare program. I spoke with Senator Benson on the senate finance committee and he said, “I want you to remember one thing. You’ll never get another program with the kind of strength and flexibility and innovation possible, and populations that it covers, as the Medicaid program. Please, just fix it. Don’t try to replace it.”

I hope that we will be able somehow to continue to sustain our nation’s super safety net.
PANEL 3: QUESTIONS AND ANSWERS

Joanne Kenan

We started this morning with Congresswoman Dingell. She returned to the topic of long-term care several times, which is the true silent part of our health care system. With all the resources at her disposal (and recalling that Chairman Dingell was not exactly a shy, retired guy), she illustrated that at the end of life, we are all vulnerable. She talked about how hard it was even for her to get him the caregiving she wanted him to have at the end of life. It is suitable that Diane Rowland brought our attention back to long-term care, because on economic panels, and today’s was excellent, we often forget its importance. One of the debates that emerges every year is about what we can fix through focusing on value and what portion of the problem is prices. That pendulum has swung back and forth in the years that I have been covering health, and the years that Libby has been both practicing medicine and covering health. (By the way, together we employ a statistically significant share of the health care press corps!) The pendulum has very much swung back to prices. Maybe that has to do with Uwe’s death since he was so forceful that we all stopped to think about high health care prices, but there has also been extensive research by Niall’s group and others this year. We have somebody on the panel who is championing continued work on the value question. We have someone here who is telling us it is mostly prices. This morning, Mike Chernew told us that increased value will not give us much, but we should be grateful for the little we get since otherwise everything might still be getting worse. Niall, you are focused on prices. Where is the intersection? How far does the value push that Duke is still cheerleading get us?

Susan Dentzer

Are those factors mutually exclusive? You could construct an umbrella of value in which prices has a front and center role.

Joanne Kenan

We should discuss this because it has been debated in an either/or way. We hear that none of the value initiatives have worked—that it is all prices. Right or wrong, this is the common dialogue.

Niall Brennan

I am in the price camp, but I was also in the value camp. I spent seven years at CMS and engaged in cheerleading for the ACA. I think value work can, as Mike said, do a little, and it is easier for value to succeed when you are a price setter like Medicare, because you can constrain prices by regulation. I think where value has struggled is in the commercial sector and it will continue to struggle if most value-based interventions are only rearranging the deck chairs on the fee-for-service Titanic. It can be value-based and wonderful bundles, or other iterations, but it is still fee-for-service underneath. People will always compute how much they are losing compared to life under fee-for-service. The logical, although difficult conclusion, is moving towards a global capitation-type approach, and sweeping away much of the detritus that distorts incentives and how providers are paid.

Susan Dentzer

We would approach this “if” from the perspective of the care pathway. We are deconstructing health care at the most basic level. We need to declare that if a service is unnecessary, there is no correct price for it. It is simply wasteful. Ridding the system of it is as critical as analyzing and developing the best payment model. What services should be done? We have leading obstetricians in the state who admit, “We honestly don’t know why we’re still doing a procedure this way.” You reply, “Well, I have an idea. It’s because you’re getting paid to do it this way.” I do not pretend to know how much of this we can spread throughout the health care system. At least in this case, it
is obvious that there are alternatives that cost significantly less. Then, you can consider the value model as opposed to bringing prices down. I do agree that the top-down piece, as Mike’s work has amply demonstrated, does not always work.

**Sabrina Corlette**

Much of the value agenda that Niall was working on at CMS, and what emerged from the ACA, was born from the HMO/managed care backlash in the late 1990s. Think of Mike Chernew’s *spoonful of sugar*—we will improve quality, impose quasi-capitation, but it will not be that horrible HMO stuff that we lived through in the mid-1990s. Public opinion polling shows that people are discussing their pocketbook concerns: cost, cost, cost. We have tapped out on deductibles as a cost control mechanism. We need something else. It will have to be ways to lower prices and maybe you put sugar on it to make it more palatable here on the Hill. If we have learned anything from the last 15 years, the value agenda will not get us where we need to go.

**Joanne Kenan**

As one of the earlier speakers said, and we found it in our polling with Harvard, the public is fed up with pricing, but they also do not look at the full cost, and they all think it is somebody else’s fault. They do not want anything to change about their access to whatever they want. If you are an economist or policy maker, will that make your life easier or more difficult?

**Len Nichols**

Terrific panel and framing. Niall, I think you said that we try these win-win approaches because we do not want anybody to get hurt and we know they have members of congress that will protect them. Here we are. We are not going to get from A to B without pain, right? Despite all this talk, “Well, we tried value-based, now we are going to get serious about prices,” somebody will lose when you play that game. It seems to me that we will all need to bear some pain. Without such a consensus, there will always be one guy who will defend himself in the finance committee. Can we find a collaborative solution?

**Susan Dentzer**

This is like the discussion in North Carolina on the commercial side, because the five health systems, including Duke, recognize the jig is up. To achieve a 0% trend in five years, the status quo is not an option, recognizing that you will not continue to stoke your NICU with infants who do not need to be there. In fact, the goal should be to close NICUs, because you do not need them, or at least we will not need the current NICU capacity. It is painful to get everybody on-board. Gene Washington at Duke says when they have these discussions, they must tell the CFO to take the afternoon off and go to the movies, because it is so mind boggling to consider turning this amazing health system battleship in a very new direction. To your point, a collaboration must happen.

**Niall Brennan**

I certainly agree with Susan on the CFO point. Show me a hospital CFO or CEO who has said publicly that in five years’ time our physical and financial footprint will be 15% less than it is today, and I will show you a hospital CFO or CEO that was fired the next day by their board. Patrick and Mandy are great personal and professional friends, and they both have considerable political capital that they are spending in North Carolina to cultivate this collaborative action. I am not optimistic that this can be widely replicated across the country, but, of course, I could be wrong.

**Diane Rowland**

When we used to talk about containing cost, we talked about regulation, health planning, or enacting rate setting as Maryland did. Now, we are in this world where everything must be framed in a competitive context, yet we acknowledged throughout today that there is no real competitive market in health care. We say, if we present the right incentives, the system will respond. When will the incentives be outweighed by the need to go back to some form of regulation?

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*We need to declare that if a service is unnecessary, there is no correct price for it. It is simply wasteful. Ridding the system of it is as critical as analyzing and developing the best payment model.*
Public opinion polling shows that people are discussing their pocketbook concerns: cost, cost, cost. We have tapped out on deductibles as a cost control mechanism. We need something else.

Stuart Guterman

I have two reactions. First, when we discuss pain, let me remind everyone that we spend well over $3 trillion a year on health care, substantially more than any other country in the world. If pain means that 10 years from now, instead of spending $4 trillion, we only spend $3.5 trillion on health care, I think most people would say that such a spending level does not exactly qualify as pain. I think we should start by honestly considering how we could most efficiently allocate the current, excessive spending. Second, on the concept of value, I think Susan is spot on. Value, by itself, means a combination of price and quality. To those who say that value-based purchasing, and related activities, have not accomplished anything, I would ask them to remember how we talked about health care 20 years ago. We barely mentioned the word quality, or else we assumed that the U.S. had better health care quality than anybody else in the world because we spent more. I think the value agenda has had an effect. The question when you are doing evaluations is always, compared to what? A big problem we have is depending on individual policies to fix the entire set of problems that the health care sector faces. That is unrealistic. We also, obviously, have difficulty comparing what we have accomplished to what would have happened in the absence of new policies. We have changed the health care sector, and the fact that we are having a panel like this means that we have substantially changed the whole conversation about health care trying to do the things that we keep saying do not work.

Joanne Lynn, Altarum Program to Improve Elder Care

I am at the end of my rope these days. Today, we have noted multiple, serious challenges. We face a world within a decade in which half of elderly people will not have homes. We will be writing $10,000 prescriptions for people who cannot get supper. The gap between the haves and the have nots continues to grow. There are clearly problems from birth to old age, but the number of frail elderly is about to double, and we have no planning in that arena. Diane mentioned it. Debbie Dingell started us off this morning discussing long-term care issues – a major source of challenges. Should we be considering a political strategy? As Stu said earlier, it seems that the policies we know could work are not politically plausible, and the policies that are politically plausible we know do not work. We must change what is politically plausible to get to the actions that would work. That requires considering power relationships and how to galvanize public opinion so that it becomes possible to take on the pain that Len mentioned. Our nouns and our verbs and our polite sentences are simply not enough. We must think in terms of how to get people marching in the streets, recognizing that they are going to die, and that they are likely going to live with serious chronic illnesses and disabilities, and that the best we can do is to make it plausible to live reasonably comfortably. There are no polio immunizations for frailty and old age! It seems that we have framed the problem incorrectly to be dealing with this small piece of the puzzle, which prevents us from getting to the pain point that we need. Time is running out between the frustration of the public, and the cost and the calamities that we have built in with Social Security and Medicare, for example, exhausting the trust funds, and the enormous rise in the number of very sick elderly, and sending a massive proportion of our young black men to prison. We have set up a calamity that is predictable in about 10 years. It will be worthless to raise my grandchildren in this country. We must start discussing power and politics.

Susan Dentzer

Joanne, you despair about the end of life. I will despair about the beginning of life. We know that over 80% of health status is driven by income and education, and that starts at birth. Look at the level of investment in this country for those aged 0 to 3 years, for example, in early education. We build poor health into children with high obesity rates, etcetera. This country does not have enough money to care for the sick people we produce regularly by neglect from years 0 to 3.
Joanne Lynn

Half of U.S. children have their births paid for by Medicaid. They are born into poverty, and we are doing nothing about it! The powerful are eating lunch. Where is everybody else?

Susan Dentzer

I take your point about housing. We have a housing affordability crisis like we have not had since the Great Depression and it is not even on the radar. This requires collective action.

Niall Brennan

All great points. This could become an extended political philosophy debate! The housing point is fascinating for me, because Kaiser—an HCCI member for whose support I am very grateful—launched a homelessness initiative in the last year. We praised the heavens for this. On the one hand, it is a wonderful initiative, but, on the other hand, as a country, we would rather overpay health insurance companies and providers so that they have the money enabling them to address homelessness rather than directly attacking the root causes. To me, that is simply insane.

Joanne Kenen

I was just about to mention RWJF. Their very readable annual message connects health and housing.

Katherine Hempstead

That is a great point. I want to circle back to what Stu said and make a comment about data. The fact that we are having a very different conversation now than we might have had in the past, emphasizing health care prices, is largely because we know much more than we did in the past. This is a testament to the importance of claims data about which I heard from almost everybody on this panel. Niall and Susan used HCCI data. Sabrina talked about the surprise billing issue, which was put on the map because of people’s analysis of HCCI data and the research that comes from that. And then the journalism that follows. And finally, driving the narrative (along with Chapin’s superb work) is powered by claims data coming from employers and from APCDs. There is very strong public interest in that data. Much of our access has been at the whim of different actors in the private sector that giveth and taketh away as Niall so importantly noted. I want to make sure that everybody is aware that today’s conversation, and many projects and initiatives that may be helpful in addressing the cost and other issues, are driven by claims data. Thus, maintaining broad access to claims data is imperative. Thank you.

Joanne Kenen

We are supposed to wrap up now. There is a lunch and a chance for people to continue the conversation. And since it is health care, you may need lots of scotch or wine to go with it!