SYMPOSIUM ON SUSTAINABLE U.S. HEALTH SPENDING
BEYOND THE ACA
Health Policy and Sustainable Health Spending
Washington DC, Tuesday, July 18, 2017

SYMPOSIUM MONOGRAPH
Paul Hughes-Cromwick, Michael Bloem, and Ani Turner, Editors
November 17, 2017

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This monograph is the result of a meeting held in Washington, DC, on July 18, 2017. It is the seventh such meeting organized by the Altarum Center for Sustainable Health Spending (CSHS) and was supported by the Robert Wood Johnson Foundation for the sixth consecutive year. We are grateful to the foundation for its continued support that has imparted continuity, visibility, and prestige to the event. Of course, 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 Trend Reports—products that are linked to the symposium funding—stimulates us to track important developments and keep pace with emerging changes affecting the health economy.

We received valuable advice guiding the entire symposium project from our colleagues Charles Roehrig, George Miller, and Corey Rhyan. Superb editorial input and formatting was provided by Audrey Hughes and Chris Sheppard. Very special thanks to Erin Duggan Butto, our symposium Ambassador of Quan. We also thank our center’s National Advisory Committee for their expertise, support and general counsel.

Please note: We have edited the July 18, 2017 presentations for clarity, and have added links, some of which stem from activities occurring following the symposium.

A complete (4-hour) video of the event is available at: www.altarum.org/cshs/meetings. This site also contains the materials for all of our previous meetings.

For any questions or comments, please contact:
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Stuart Altman, PhD, is the Sol C. Chaikin Professor of National Health Policy at The Heller School for Social Policy and Management, Brandeis University, is an economist with five decades of experience. He has demonstrated leadership in health care through service on numerous government advisory boards, including service for Planning and Evaluation/Health at the U.S. Department of Health Education and Welfare (HEW), for the Prospective Payment Assessment Commission (ProPac), and for the National Bipartisan Commission on the Future of Medicare. In November 2012, Governor Deval Patrick appointed Dr. Altman to chair Massachusetts’ Health Policy Commission.

Dr. Altman has been recognized as a leader in the health care field by Health Affairs and by Modern Healthcare, which has named him among the 30 most influential people in health policy over the previous 30 years, and one of the top 100 most powerful people in health care. He has served on the Board of Directors of several for-profit and not-for-profit companies and is a published author of numerous books and journal articles.

From diabetes, cancer and heart disease to mental health, children’s health and hospital care, IHPI members study issues related to a broad range of conditions.

His research is focused on effects of race, ethnicity, gender and insurance coverage on access to care and clinical outcomes, and the impact of physician specialty and organizational characteristics on the quality of care for cardiovascular disease, cancer, diabetes and other major health conditions. He has led numerous studies assessing access to care, quality of care, and health care disparities.

Ayanian came to the U-M from Harvard Medical School, where he served as professor of medicine and of health care policy. He also was a professor in health policy and management at the Harvard School of Public Health, and a practicing primary care physician at Brigham and Women’s Hospital in Boston.

From 2008-13, he directed the Health Disparities Research Program of Harvard Catalyst, Harvard’s Clinical and Translational Sciences Center, the Outcomes Research Program of the Dana-Farber/Harvard Cancer Center, and the Harvard Medical School Fellowship in General Medicine and Primary Care.

Ayanian graduated from Duke University, Harvard Medical School, and the Harvard Kennedy School of Government. After a residency in internal medicine at Brigham and Women’s Hospital, he completed fellowships in general internal medicine and health services research at Harvard. He began his faculty career at Harvard in 1992.

Elected to the Institute of Medicine, the American Society for Clinical Investigation, and the Association of American Physicians, he also is a fellow of the American College of Physicians. In 2012, he received the John M. Eisenberg Award for Career Achievement in Research from the Society of General Internal Medicine, and his past honors include the Generalist Physician Faculty Scholar Award from the Robert Wood Johnson Foundation.
Jessica Banthin, Jessica Banthin came to CBO in June 2011, arriving as a senior advisor on health care analyses. She was promoted two years later to the position of deputy assistant director. During her time at CBO, she has written and managed several reports and cost estimates related to the Affordable Care Act. She directs the development and application of the agency’s Health Insurance Simulation model as well as other models used to support estimates of how changes in policy would affect health insurance coverage and the federal budget.

Before joining CBO, Dr. Banthin worked for many years at the Agency for Healthcare Research and Quality (AHRQ), where she directed the Division of Modeling and Simulation. At AHRQ, she helped design and analyze the Medical Expenditure Panel Survey, which yields nationally representative data on health care expenditures, premiums, and more.

Her research has spanned a range of health care issues, including trends in out-of-pocket spending, employment-based coverage, eligibility for and enrollment in Medicaid and the Children’s Health Insurance Program, the “crowding out” of private insurance by public programs, premiums in the individual market, prescription drug expenditures, and the impact of policy reforms on costs overall, access to care, and families’ out-of-pocket expenses. Dr. Banthin received her Ph.D. in economics from the University of Maryland and her A.B. from Harvard University.

Sheila Burke, is a strategic advisor in Baker Donelson’s Washington, D.C., office and serves as chair of the Firm’s Government Relations and Public Policy Group. In addition to her role at the Firm, Ms. Burke continues as a faculty member at the John F. Kennedy School of Government at Harvard University where she teaches a number of health policy courses and co-directs a public policy simulation exercise. From 1996 to 2000, she was executive dean and a lecturer in public policy at the Kennedy School. She also serves as Distinguished Visitor at the O’Neill Institute for National and Global Health Law at Georgetown University.

Ms. Burke served for 19 years on Capitol Hill. Early in her career, she was a member of the staff of the Senate Finance Committee responsible for legislation relating to Medicare, Medicaid and other health programs. She ultimately became deputy staff director of the Finance Committee. She went on to serve as deputy chief of staff to Senate Majority Leader Bob Dole and later as his Chief of Staff. In these roles, she was involved with numerous legislative issues including those related to Medicare, Medicaid and the Maternal and Child Health programs, welfare reform, budget reconciliation and the previous legislative efforts to reform health care. In 1995, she was elected as secretary of the Senate, which is the chief administrative officer of the United States Senate.

In addition to her government and academic experience, Ms. Burke served as the deputy secretary and chief operating officer of the Smithsonian Institution, the world’s largest museum and research complex. As the chief operating officer, she had responsibility for the overall operations of the 19 individual museums and galleries, the National Zoo and nine research facilities located in Washington, D.C., five states and 150 foreign countries with revenues of approximately $1 billion and an endowment of $1 billion. During her seven-year tenure at the Smithsonian, she oversaw the completion of the National Air and Space Museum’s Udvar-Hazy Center, the National Museum of the American Indian and the renovation of the Smithsonian’s Reynolds Center for Art and Portraiture. She was also involved in the initial planning for the National Museum of African American History and Culture. She began her Smithsonian tenure in 2000 as the undersecretary for American Museums and National Programs, becoming deputy secretary and chief operating officer in 2004.

James Capretta, is a resident fellow and holds the Milton Friedman Chair at the American Enterprise Institute, where he studies health care, entitlement, and US budgetary policy, as well as global trends in aging, health, and retirement programs. In 2015 and 2016, he directed two major studies: one on reforming US health care according to market principles and consumer choice, and the second on reforming major federal entitlement programs to promote greater personal responsibility, focus limited resources on those most in need, and lower long-term federal expenditures.
Mr. Capretta spent more than 16 years in public service before joining AEI. As an associate director at the White House’s Office of Management and Budget from 2001 to 2004, he was responsible for all health care, Social Security, welfare, and labor and education issues. Earlier, he served as a senior health policy analyst at the US Senate Budget Committee and at the US House Committee on Ways and Means. From 2006 to 2016, Mr. Capretta was a fellow, and later a senior fellow, at the Ethics and Public Policy Center.

Mr. Capretta’s essays and reports include “Improving Health and Health Care: An Agenda for Reform” (AEI, 2015); “The Budget Act at Forty: Time for Budget Process Reform” (Mercatus Center, 2015); and “Increasing the Effectiveness and Sustainability of the Nation’s Entitlement Programs” (AEI, 2016). His book chapters include “Health-Care Reform to Lower Costs and Improve Access and Quality” in “Room to Grow: Conservative Reforms for a Limited Government and a Thriving Middle Class” (YG Network, 2014); and “Reforming Medicaid” in “The Economics of Medicaid: Assessing the Costs and Consequences” (Mercatus Center, 2014).

He has been widely published in newspapers, magazines, and trade journals, including Health Affairs (where he is a member of the Editorial Board), The JAMA Forum, National Review, The Wall Street Journal, and The Weekly Standard. His television appearances include “PBS NewsHour,” Fox News, CNBC, and Bloomberg Television.

Mr. Capretta has an M.A. in public policy studies from Duke University and a B.A. in government from the University of Notre Dame.

Ceci Connolly, a nationally-recognized health care leader, took over as president and CEO of the Alliance of Community Health Plans in January 2016. In her role, she works with some of the most innovative executives in the health sector to provide high-quality, evidence-based, affordable care. She is passionate about transforming America’s system to deliver greater value to all.

Connolly has spent more than a decade in health care, first as a national correspondent for the Washington Post and then in thought leadership roles at two international consulting firms. She is a leading thinker in the disruptive forces shaping the health industry and has been a trusted adviser to C-suite executives who share her commitment to equitable, patient-centered care.

She is co-author of the book LANDMARK: The Inside Story of America’s Health Law and What it Means for Us All, has covered six presidential campaigns and numerous natural disasters including Hurricane Katrina. She is the first non-physician to receive the prestigious Mayo Clinic Plummer Society award for promoting deeper understanding of science and medicine and in 2001 was awarded a fellowship to Harvard’s Kennedy School of Government.

For four years, Connolly served on the board of Whitman-Walker Health, a $26 million non-profit, community health center, serving 15,000 clients a year. She is a founding member of Women of Impact (WOI) for Healthcare and serves on the national advisory committee of the Altarum Institute Center for Sustainable Health Spending. She is a graduate of Boston College.

Rena Conti, PhD, Rena M. Conti, PhD is an expert on the financing, regulation and organization of medical care, with an emphasis on biopharmaceutical markets and oncology practice. She is an Assistant Professor of Health Policy in the Department of Pediatrics, section of hematology/oncology, and the Department of Health Studies. Dr. Conti is a 2007 graduate of the Harvard University Interfaculty Initiative in health policy (economics concentration). She currently serves on the Government Affairs committee for the American Society of Clinical Oncology and is co-director of the economics working group for Cancer Therapy Evaluation Program for the National Cancer Institute.

John Cutler, Esq, is both a Senior Fellow for National Academy of Social Insurance as well as a special advisor to the Women’s Institute for a Secure Retirement. He is also a member and incoming chair of AcademyHealth’s Long-Term Services and Supports (LTSS) Interest Group.
He retired from the Federal government in 2015 after serving in various agencies including the U.S. Office of Personnel Management, where he was responsible for bringing the Federal Long Term Care Insurance Program online, and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). Prior to that he worked for eight years at AARP, with responsibility for regulatory and compliance matters involving AARP’s long term care and Medicare supplemental insurance as well as other products. He was also previously a partner in MacMeekin, Cutler & Woodworth, a small law firm in Washington, D.C., dedicated to Pacific and territorial legal matters.

Cutler holds a BA degree from the University of Virginia in Government and Foreign Affairs and a Juris Doctor from the University of Georgia. He is a member of the Bar in the District of Columbia. He is also active in various committees of the Society of Actuaries and the Fairfax County (Virginia) Long Term Care Coordinating Committee.

Darrell Gaskin, PhD, is the William C. and Nancy F. Richardson Professor in Health Policy and Director of the Johns Hopkins Center for Health Disparities Solutions. Dr. Gaskin is a health services researcher and health economist who is internationally known for his expertise in health disparities, access to care for vulnerable populations, and safety net hospitals. He seeks to identify and understand barriers to care for vulnerable populations; and to develop and promote policies and practices that will improve access to care for the poor, minority and other vulnerable populations, and eliminate racial/ethnic and socioeconomic disparities in healthcare. His current projects explore the relationship between “place” and healthcare disparities and examine racial/ethnic and socioeconomic disparities in hospital care.

Dr. Gaskin’s has published in the leading health services and public health research journals, including American Journal of Public Health, HSR, Health Affairs, Inquiry, Medical Care, Medical Care Research and Review, and Social Science and Medicine. Currently, he serves on the Editorial Boards of HSR, Medical Care and Medical Care Research and Review. He is Chairman of the Board of Directors of AcademyHealth and a member of the Center for Health Policy Development Board, the board of directors for the National Academy of State Health Policy. His advice is sought in federal and state health policy. He was a member of the Congressional Black Caucus Commission on the Budget Deficit, Economic Crisis, and Wealth Creation. He is a former member of the Board of Directors of the Maryland Health Insurance Plan, the state’s high-risk pool. He served as the Vice Chairman of the Board of Directors of the Maryland Health Benefits Exchange Commission.

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 POLITICO Pro’s health care editor. 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 September 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.

Jeanne Lambrew, PhD, is a senior fellow at The Century Foundation and an adjunct professor at the NYU Wagner Graduate School of Public Service. Her writing, research, and teaching focus on policies to improve health care access, affordability, and quality.

Previously, she worked in the Obama Administration. In the first two years, she was the director of the Office of Health Reform at the U.S. Department of Health and Human Services (HHS). In that role, she coordinated work toward passage and the implementation of the Affordable Care Act (ACA). From 2011 to January 2017, she worked at the White House as the deputy assistant to the president for health policy. In that capacity, she helped ensure execution of the president’s health policy agenda including implementation and defense of the ACA. Her portfolio also included policy regarding Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and public health. She helped to develop positions on legislation and executive actions, direct special projects and analyses, review regulations, manage short-term challenges, set the long-term agenda, and coordinate work with key departments.

Prior to joining the Obama Administration, Lambrew was an associate professor at both the Lyndon B. Johnson School of Public Affairs in Austin, Texas (2007–2008) and the George Washington University School of Public Health (2001–2007). She also served as senior fellow for health policy at the Center for American Progress (2003–2007). In 1996, she was a research faculty member at Georgetown University.

Lambrew also served in the Clinton Administration in the HHS Office of the Assistant Secretary for Planning and Evaluation (1993–1995), the White House National Economic Council (1997–1999), and the White House Office of Management and Budget (2000–2001). In these roles, she helped coordinate health policy development, evaluated legislative proposals, and conducted and managed analyses and cost estimates with HHS and other relevant federal agencies. She led White House efforts to draft and implement the Children’s Health Insurance Program and helped develop the president’s Medicare reform plan, initiative on long-term care, and other health care proposals.

Anne Montgomery is the Deputy Director for Altarum Institute’s Center for Elder Care and Advanced Illness and a visiting scholar at the National Academy of Social Insurance. From 2007 to 2013, Ms. Montgomery served as senior policy advisor for the U.S. Senate Special Committee on Aging, where she was responsible for developing hearings and legislation to improve nursing homes and home and community-based services in Medicaid, dually eligible beneficiaries, health care workforce issues, elder abuse, dementia care, and community and social support services for older adults. She has also served as a senior health policy associate with the Alliance for Health Reform in Washington, DC; a senior analyst in public health at the U.S. Government Accountability Office; and a legislative aide for the Ways & Means Health Subcommittee.

Based in London as an Atlantic fellow in public policy in 2001–2002, Ms. Montgomery undertook comparative policy analysis of the role of family caregivers in the development of long-term care in the United Kingdom and
The United States. During the 1990s, she worked as a health and science journalist covering the National Institutes of Health and Congress.

A member of the National Academy of Social Insurance and Academy Health, Ms. Montgomery has an M.S. in journalism from Columbia University and a B.A. in English literature from the University of Virginia and has taken gerontology coursework at The Johns Hopkins University.

**Charles Roehrig, PhD**, is Founding Director, Altarum’s Center for Sustainable Health Spending (CSHS), and an Institute Fellow. His research interests include timelier tracking of health spending, determining its sustainable growth rate, and modeling its future growth.

Dr. Roehrig has overseen development of the Altarum Health Sector Economic Indicators, which provide monthly tracking of health spending, prices, utilization, and employment. He developed the *Triangle of Painful Choices* to illustrate the link between the federal budget and the sustainable rate of health spending. He also led the development of estimates of national health spending by medical condition, including spending on prevention, and has extended this research to include the impact of disease prevalence on expenditure growth.

Dr. Roehrig is currently studying the impact of primary prevention on health spending and is modeling the impact of business cycles on health spending growth. He also has many years of experience in modeling health workforce supply and requirements. His work has been published in *Health Affairs* and the *New England Journal of Medicine*, and he blogs regularly for Altarum’s Health Policy Forum and *Health Affairs*.

In addition to his applied research, Dr. Roehrig has published in the field of theoretical econometrics in academic journals such as *Econometrica* and the *Journal of Econometrics*.

He holds a PhD in economics from the University of Michigan, an MS in statistics from the University of Michigan, and a BA in economics from Amherst College.

**Hemi Tewarson**, is the director for the National Governors Association Center for Best Practices’ Health Division, where she oversees all the Health Division projects which include Medicaid transformation and coverage, Medicaid data systems, health care delivery and payment system reform, workforce, opioids, and behavioral health and social determinants.

Prior to joining NGA, Ms. Tewarson had decades of experience in health care policy in the private and public sectors. She served as senior attorney for the Office of the General Counsel at the U.S. Government Accountability Office and was in private practice as a health policy attorney where her practice included advising states on how to reform their Medicaid programs.

Ms. Tewarson holds a J.D. and a master’s degree in public health from the George Washington University and a bachelor’s degree in psychology from the University of Pennsylvania.

**Chapin White, PhD**, is a 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.

He has been a lead researcher on two multi-site qualitative studies of the impacts of health reform—the first, funded by the Robert Wood Johnson Foundation, examined ACA-driven changes in health insurance markets in eight
metropolitan areas; the second, funded by the American Medical Association, examined the impacts of payment reform on physicians and their practices. White has conducted projects analyzing the effects of changes in Medicare payments for inpatient hospital care on hospitals’ operating expenses, the prices paid by private insurers, and the volume of services provided.

Before joining RAND, White was a senior health researcher at the Center for Studying Health System Change (2010–2013), and a principal analyst at the Congressional Budget Office (2005–2010). White holds a Ph.D. in health policy from Harvard University.

Rodney Whitlock, is a veteran health care policy professional with more than 20 years of experience working with the US Congress, where he served as health policy advisor and as Acting Health Policy Director for Finance Committee Chairman Chuck Grassley of Iowa and, earlier, on the staff of former US Representative Charlie Norwood of Georgia.

During his years with Representative Norwood, Rodney managed the Patients’ Bill of Rights, which passed the House in 1999 and 2001. In February 2005, Rodney left the office of Congressman Norwood to join the Finance Committee Staff as a health policy advisor to Chairman Grassley. In that capacity, he was lead Senate Republican staffer for Medicaid legislation from 2005 to 2010, including the Deficit Reduction Act of 2005, the Tax Relief and Health Care Act of 2006, the CHIP Reauthorization Act of 2007 and 2009, and the Affordable Care Act of 2010. He continued to serve Senator Grassley through 2015 working on all health-related issues.

In 2007, Rodney worked on the Children’s Health Insurance Program Reauthorization Act, which passed Congress twice and was subsequently vetoed twice by President George W. Bush. Rodney spent 2009 and 2010 deeply engaged in health care reform legislation. Late in 2010, he became the Acting Health Policy Director for Senator Grassley, and shepherded the Medicare and Medicaid Extenders Act of 2010 into law. Following his tenure in Senator Grassley’s Congressional office, Rodney served as Health Policy Director in the Senator’s personal office.

Gail Wilensky, PhD, is an economist and senior fellow at Project HOPE, an international health foundation. She directed the Medicare and Medicaid programs from 1990 to 1992 and served in the White House as a senior health and welfare adviser to President GHW Bush. Dr. Wilensky currently serves as a trustee of the Combined Benefits Fund of the United Mine Workers of America and the National Opinion Research Center, is on the Board of Regents of the Uniformed Services University of the Health Sciences (USUHS) and the Geisinger Health System Foundation. She also served as president of the Defense Health Board, a Federal advisory to the Secretary of Defense, was a commissioner on the World Health Organization’s Commission on the Social Determinants of Health and co-chaired the Dept. of Defense Task Force on the Future of Military Health Care.

She is an elected member of the Institute of Medicine and has served two terms on its governing council. She is a former chair of the board of directors of Academy Health, a former trustee of the American Heart Association and a current or former director of numerous other non-profit organizations. She is also a director on several corporate boards.

From 1997 to 2001, she chaired the Medicare Payment Advisory Commission, which advises Congress on payment and other issues relating to Medicare and previously chaired one of its predecessor commissions, the Physician Payment Review Commission. From 2001 to 2003, she co-chaired the President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans and in 2007, served as a Commissioner on the President’s Commission on Care for America’s Returning Wounded Warriors (Dole/Shalala Commission).

Dr. Wilensky testifies frequently before Congressional committees, serves as an advisor to members of Congress and other elected officials, speaks nationally and internationally before professional, business and consumer groups. She received a bachelor’s degree in psychology and a Ph.D. in economics at the University of Michigan and has received several honorary degrees.
Paul Hughes-Cromwick is the Co-Director of Altarum’s Center for Sustainable Health Spending, where he has worked since 2002. He has been involved in health care economic and policy analyses since receiving his master’s degree in 1981. He leads outreach activities and business development for the Center, which was launched by Altarum as a critical systems issue in May 2011.

Before working at Altarum, Mr. Hughes-Cromwick worked for the University of Michigan School of Nursing; the Henry Ford Health System; the University of Pittsburgh Graduate School of Public Health; the State of Connecticut, where he was research director for the Connecticut Partnership for Long Term Care Insurance; and the U.S. Department of Health and Human Services in the Office of the Assistant Secretary for Planning and Evaluation. He was chairman of the board at Care Choices HMO in Farmington Hills, Michigan, until its sale and is currently on the board of trustees of SCL Health System in Broomfield, Colorado. He is a member of the American Economic Association; AcademyHealth; and the National Association for Business Economics, where he served as chairman of the Health Economics Roundtable from 2009–2015.

Mr. Hughes-Cromwick has a BS in mathematics and philosophy from the University of Notre Dame and an MA in applied economics from Clark University, where he completed all nondissertation requirements toward a PhD. His areas of expertise include health economics, health policy analysis and forecasting, and health sector economic indicators.

Ani Turner is Co-director of Altarum Institute’s Center for Sustainable Health Spending, where she studies drivers of health spending and the economic impact of investments in social and environmental factors that determine health and life outcomes. She leads the Center’s monthly tracking of national health sector employment and has two decades of experience in health workforce modeling and analysis.

Working with government and commercial clients for more than 25 years, Ms. Turner has developed forecasting models and conducted analyses of health care resources, costs, and quality for the U.S. Department of Health and Human Services, the U.S. Department of Defense, individual states, and health plans.

Current foundation-funded research supports both the improvement of the health of underserved people in Detroit and the making of the business case for investments in greater racial equality.

Ms. Turner holds a bachelor’s degree in mathematics, summa cum laude, and a master of arts degree in applied economics with a concentration in labor economics, both from the University of Michigan.

Michael Bloem is a master’s student at the University of Michigan’s Gerald R. Ford School of Public Policy, he is working with the Altarum team on tracking health spending indicators, providing analysis of current health sector trends, and measuring overused services in medical care. Prior to graduate school, Mr. Bloem worked as a Research Associate in the University of Michigan Law School’s Empirical Legal Studies Center. As an undergraduate student, Mr. Bloem spent time working as a Research Assistant at the Center for Social Research at Calvin College, and as an intern in the Division of Consumer and Community Affairs at the Federal Reserve Board of Governors.
SYMPOSIUM AGENDA

With funding from the Robert Wood Johnson Foundation
Altarum Institute Center for Sustainable Health Spending presents

Beyond the ACA: Health Policy and Sustainable Health Spending

Tuesday, July 18, 2017  8:20–2:15
Kaiser Family Foundation Barbara Jordan Conference Center, 1330 G Street NW, Washington, DC

8:20–8:55  Continental Breakfast and Welcome
   Ani Turner, Co-Director, Altarum Center for Sustainable Health Spending—Welcome

9:00–10:00  I. The Budget and Future Policy Landscape
   Ceci Connolly, President & CEO, Alliance of Community Health Plans—Moderator
   Stuart Altman, President & CEO, Kaiser Family Foundation
   Jessica Banthin, Deputy Assistant Director, U.S. Congressional Budget Office
   Sheila Burke, Strategic Advisor, Baker, Donelson, Bearman, Caldwell & Berkowitz, PC

10:05–11:00  II. Long Term Care in America: Problems, Policies and Prospects
   Anne Montgomery, Deputy Director, Altarum Center for Elder Care & Advanced Illness—Moderator
   John Cutler, Sr. Fellow, National Acad. of Social Insurance & Chair-elect, AcademyHealth
   LTSS Interest Group
   Rodney Whitlock, Vice President, Mintz Levin Strategies
   Hemi Tewarson, Health Division Director, National Governors Association

11:05–12:20  III. Health, Health Care and Cost Drivers
   Katherine Hempstead, Senior Adviser to the Executive VP, Robert Wood Johnson Foundation—Moderator
   Darrell Gaskin, Professor, Health Policy and Management, Johns Hopkins University
   Chapin White, Senior Policy Researcher, RAND Corporation
   Rena Conti, Assistant Professor, Departments of Pediatrics & Public Health Sciences, University of Chicago
   Charles Roehrig, Fellow & Founding Director, Altarum Center for Sustainable Health Spending

12:25–1:40  IV. Beyond the ACA: Repeal, Replace, Repair, Reconstitute—The Outlook
   Joanne Kenen, Executive Editor, Health Care, POLITICO—Moderator & Rapporteur
   James Capretta, Resident Fellow & Milton Friedman Chair, American Enterprise Institute
   Jeanne Lambrew, Senior Fellow, Century Foundation
   John Ayanian, Director, Institute for Healthcare Policy & Innovation, University of Michigan
   Gail Wilensky, Economist & Senior Fellow, Project Hope

1:40–2:15  Lunch and Informal Discussions
WELCOME AND INTRODUCTION

Ani Turner

Welcome! Welcome to our speakers, welcome to all of you here in person, and welcome to everyone joining us via webcast. My name is Ani Turner and I am co-director of the Center for Sustainable Health Spending at Altarum. On behalf of our Center, I want to thank the Robert Wood Johnson Foundation for their ongoing support of what is now the sixth annual Sustainable Health Spending Symposium.

When our Center was first created and we began having these meetings, the country was emerging from the Great Recession, we saw the passage of ACA and initial implementation, and today, as you all know, we are watching repeal and replace activities on almost a minute-by-minute basis. But, as impactful and as important as those events are, the issues that we are discussing today go beyond those events, for example: the share of our societal resources going toward health care; issues of health equity; the financial pressure on our government and on our family budgets; sustainability concerns; and caring for an aging population with a system that was not designed for the way that our society ages today. These are all topics we will be covering today and I am sure we will be discussing for at least another six years!

I want to recognize my Co-Director, Paul Hughes-Cromwick. Paul puts this event together every year, and once again, has done an outstanding job assembling an amazing set of speakers and moderators. I also want to thank Altarum’s Communications and Public Affairs Group. They have worked tirelessly on each of the details of organizing and publicizing this event, especially Erin Butto and Sarah Litton. They have done such a good job this year that this is the first time we have had to close registration.

We do have changes in the agenda I would like to note. Many of you have received a complimentary copy of Elizabeth Rosenthal’s book. Unfortunately, we learned yesterday that she had a family emergency and is not able to be here today, but I know you will enjoy the book and we will look forward to having her on a future agenda.

For those of you who have not been to one of our symposia in the past, we pack a lot of information in this half-day session. One of the ways we do that is by keeping the information flowing almost continuously. There will be a short break in between the four panels as people trade places, but we do not have any formal breaks built into the schedule. Thus, if you need to step in and out feel free to do that. I also want to remind everyone that we are videotaping the entire event so you can relive your favorite moments, and the full video will be posted to our website shortly after this event today.

We will leave time after each panel for Q&A and we have microphones set up. For those of you on Twitter, we do have a hashtag—#CSHSustain. Finally, after the presentations we will have lunch available. For those of you able to stay a little longer we would love to invite you to join us for a bite to eat and to continue the conversation. Again, welcome. Thank you all for being here, and I will turn it over to Ceci for our first panel.
Beyond the ACA: Health Policy and Sustainable Health Spending

Ceci Connolly

Good morning, everyone. A couple of programming notes. For those of you that thought you were going to get a chance to see Drew Altman, unfortunately, he had travel nightmares yesterday trying to get here from the West Coast. His “younger brother,” Stuart, has decided to step in, and we are very grateful. Drew wanted me to convey not only his apologies for not being able to join the discussion this morning, but he also was hoping to welcome you to this wonderful meeting center. This is a suburb location, and we are very grateful to the Kaiser Family Foundation.

Let me tell you a bit about our topic, and my aim to go a little rogue. Those of you who have attended in years past know that I have a tendency to do that. What I mean by rogue is that even though the intention was for us to discuss long-term budgetary issues, I do not think we can totally ignore the news of this morning. I have been twisting a couple of the panelist’s arms and they have agreed to share their thoughts on what the latest developments in the Senate might mean, and what might be coming both in the short-term and relating to our longer-term health and budgetary conversation.

I will ask each of our esteemed panelists to start with opening remarks. We will then have a conversation up here and we encourage participation from you in the audience as well as the folks out in cyber land. We expect a lively and informative discussion.

We will begin with Jessica Banthin, who is the Deputy Assistant Director of the United States Congressional Budget Office. We were going to ask Jessica to reveal the score this morning, and I am sure she was going to do that. But now, she is probably going to have to go with another presentation!

Our second panelist is Sheila Burke who is a Strategic Advisor at Baker, Donelson, Bearman, Caldwell & Berkowitz. Many of you here today have known Sheila for several years, going back to her time in the Senate as a leader in health care policy.

I have already mentioned Stuart Altman, who is a professor at Brandeis University, as well as the chairman of the Massachusetts Health Policy Commission. I have asked Stuart to share a little bit of his perspective from that time leading the commission because I think there are terrific insights and learnings from Massachusetts, as is frequently the case in health care. He might even present a radical concept to us as we talk this morning.

We have asked Jessica to start us off with a set of real facts. How does that sound?
These projections are not intended to be a prediction of what will actually occur in the future. Rather, this is an exercise to show where we are headed if current law remains unchanged. It provides a useful yardstick or baseline that illustrates the impact of policies and what would happen if we do not change them. It is also a yardstick against which to measure policy changes, especially those that affect the very long term. For example, policies that affect Medicare or long-term care, where the effects have an impact far out in the future.

What are the implications of these projected deficits? Remember, they will not necessarily occur, but if current spending trends continue, we would see debt rise to unprecedented levels. We project that debt would rise to about 89 percent of GDP by 2027, and by the end of this projection window it would rise to 150 percent of GDP (Figure 2). What is particularly interesting about this chart is that we see the full history of debt in this country. Most of the large increases in debt are associated with wars and great calamities. Just before the vertical dashed-line, debt
increased significantly because of the Great Recession of 2007 – 2009.

What is driving this federal spending? The major health care programs are central drivers. Again, that assumes that current laws do not change. These programs include Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the subsidies for Health Insurance Marketplace coverage. In the past, people worried about Social Security, and we still do, but major health care programs are now projected to rise faster than Social Security (Figure 3). This has occurred in part because the baby boomer population begins to decrease in 2028, but spending on major health care programs keeps climbing. Net interest spending grows along with the debt, but other noninterest spending gets significantly crowded out. Spending for programs such as defense, the Supplemental Nutrition Assistance Program (SNAP), transportation, and research at the National Institutes of Health (NIH) all start to decline as a share of GDP under this scenario.

My focus is on federal spending, but federal spending is only one part of the national health care spending story (Figure 4). Medicare, Medicaid and other government spending make up 48 percent of the total. Spending by private health insurers also represents a large share, although remember that it is subsidized by the tax exclusion. Consumer out-of-pocket spending accounts for 11 percent of the total.

What constitutes the major federal health care spending programs? Medicare spending, netting out the premiums that are collected under Part B and Part D, is the largest component (Figure 5). The remaining components of federal spending are Medicaid, health insurance subsidies and related spending, and CHIP. In 2017, these components add up to over $1 trillion. Medicare is still the biggest program in the bunch. Medicaid is also quite large. Subsidies for the Marketplace are only $51 billion and CHIP is $15 billion.
billion. These major health care programs represent about 5.5 percent of GDP today (Figure 6). Thirty years from now, however, if current law does not change, it would grow to over 9 percent of GDP, easily outpacing Social Security. Net interest also grows considerably.

Another way to consider these amounts is to change the denominator to noninterest spending, because that is the spending available to support programs that benefit the population (Figure 7). Major health care programs grow from 28 percent of noninterest spending in 2017 to a whopping 40 percent in 2047.

Why is spending on major health care programs growing so quickly? We assume that these programs continue relatively unchanged because they comprise mandatory spending. The spending is “automatic,” primarily as a function of eligibility levels—such as age in the case of Medicare—thus Congress does not appropriate it each year. Therefore, it is reasonable in this projection to assume that these programs will continue to grow over time. Again, the projections are a yardstick. This is how they would grow over time if we do not make any changes.

What accounts for the growth in federal health care spending? Spending on Medicare is projected to drive much of the growth (Figure 8). Medicare grows from about 3 percent of GDP in 2017, to about 6 percent in 2047, explaining three-quarters of the change in total health care spending. Medicaid, CHIP and Marketplace subsidies altogether are a smaller portion. They grow from about 2.4 percent of GDP to 3.2 percent of GDP.

What factors are behind the growth? Our projections are formulaic: We estimate the number of people who would be eligible for these programs and then we separately project spending per enrollee based on historical averages and, with additional assumptions, project this spending over time. The first major factor driving the growth in spending is the aging of the population, since everyone becomes eligible for Medicare at age 65 (Figure 9). Aging explains a large part of this growth, but is not easily amenable to policy!

The second major factor is something we call excess cost growth. That does not mean it is excessive. Excess cost growth is an accounting term that explains how much utilization and intensity of utilization increases in excess of per capita GDP. In this projection, excess cost growth accounts for 2.8 percentage points of the difference in spending on major health care programs between 2017 and 2047.
Beyond the ACA: Health Policy and Sustainable Health Spending

To illustrate the aging population, those 65 or more years old, increases from about 15 percent of the population in 2017 to 22 percent in 2047 (Figure 10). We do not assume everyone over 65 is going to stop working or become very sick. In fact, overall, they are becoming healthier. Nonetheless, they are eligible for Medicare and we will spend money on them.

Excess cost growth is the critical factor that we as a society need to consider; that is, how much we are willing to spend on health care.

Editor’s note: This presentation is also available on the CBO website.
HEALTH SPENDING AND RELATED CHALLENGES

Sheila Burke

Well on that positive note from Jessica!

It is a pleasure to be here and I very much appreciate the opportunity to see the younger Altman and to be with all of you. Thank you, Jessica. You have done an extraordinary job of giving a sense of the complexity of the issues that we are confronting, which are neither new nor specific to this moment, but have been growing over a period of time, especially the challenges presented by both Medicare and Medicaid, and the other programs that fall within the responsibility of the federal and state governments.

The U.S. faces an interesting paradox. Spending is uncontrolled both in absolute terms and growth rates, which threatens our economy and produces questionable value in the view of many. One in four dollars is spent on health care or social services but we receive relatively low results when compared to a number of other industrialized countries, an issue that has come up repeatedly. Jessica raised an essential point: that we face critical tradeoffs. This is also not a new issue. The battle between entitlements and discretionary spending at the federal and state levels accelerates as larger percentages of our budgets are consumed by health care activities. In many states, health spending exceeds the amount of money spent on education and many of the other challenges that state governments confront. And, of course, the states also have to live within constraints imposed by balanced budget requirements.

At the federal government, you see the age-old battle between discretionary spending and entitlement spending. This pertains to everything from the Centers for Disease Control and Prevention, to the Food and Drug Administration, to nutrition programs or a variety of other functions where spending does not lie within a mandatory program. The tradeoffs are real and underlie much of our conversation today.

Last week, the Commonwealth Fund released the report Mirror, Mirror 2017. Many of you are familiar with this report that rates the performance of the U.S. among other high income countries. Data suggests we perform poorly on access to care, on administrative activities with respect to health care, and our overall efficiency. We also have larger income-related disparities in the quality of services received compared to other countries. On the positive side, the U.S. performance exceeds that of other countries with respect to certain elements of health care such as the patient-centeredness, and the treatment of very specific disease conditions, for example, myocardial infarction, strokes, and colon and breast cancer.

But we are not good at primary care and prevention. As we look at the options and the challenges we face in terms of spending, we must confront these issues of how we think about our health care system. One startling statistic that became available within the last couple of weeks: 26 million of the 17 to 24-year-olds in this country cannot qualify to serve in our military either because of obesity, the presence of chronic illness or the use of drugs. It has become a strategic challenge for this country, a security issue, as well as a set of urgent priorities.
I think we collectively appreciate that medical care accounts for a relatively small percentage of the health outcomes that we observe. Looking at the spending that Jessica described so well, we are typically considering a traditional model of the kind of spending we have done in the past. Yet, what people increasingly need are housing, transportation, and nutrition, all of which have an enormous impact on long-term health. Over the long term, we need to think beyond the traditional institutional services we have provided in the past, and move to the broad range of the social determinants of health and their critical impact on outcomes as we consider new delivery models. And we need to consider the cost implications. Providing the full range of services that are needed to keep our population healthy, will, I suspect for a period of time, be an additional cost; the return on those investments will not be seen immediately. Moving away from our traditional institution-focused care to a broader range of services that allow people to stay healthy and stay at home will hopefully yield a long-term return following a short-term investment.

Community health requires investing in, and addressing those, social needs. In the traditional Medicare and Medicaid models, care is institutionally based. We need to get beyond that traditional medical orientation, adopt a much broader perspective of needed health services, and address the disparities in our communities.

Last week, the Medicare and Social Security trustees detailed the challenges facing Medicare, and they project the depletion of the hospital insurance trust fund by 2029. Those of us who have spent time working in Senate offices (I note that Dave Nexon is in the audience), would wait every year for the trustee’s report to tell us what year the fund would go broke, and by how much that year would change. This year they say that lower hospitalizations and lower per capita spending contributed to the delay of the exhaustion date, by a single year. The trustees also describe the highly uncertain nature of projecting the cost of federal and state programs. Looking out 20, 30, or 40 years, is enormously complicated for a host of reasons, including in the short-term, for example, pending legislation.

What a difference a day makes, with Senate repeal of the Affordable Care Act today losing all of its momentum from yesterday! The short-term memory loss of members relative to what they are doing, and what they need to do, can have an enormous legislative impact. The CHIP reauthorization, for example, which comes up in the fall could have a significant effect on coverage and cost. Consider Jessica’s duty of projecting the cost of the CHIP program. The Congressional Budget Office (CBO) presumes CHIP continues but there is no certainty. Uncertainty is especially relevant to Medicaid, whether it is capped, uncapped, per capita capped, expanded, and what about all of the potential waiver variants? We expect that this Administration will be very forthright in their interest in expanding waiver opportunities. Again, this could have an enormous impact on spending, whether it constrains eligibility, increases cost sharing, introduces work-related requirements, etc.

States face substantial cost uncertainty in the short run. Should a downturn in the economy occur, with an uptick in unemployment, this would also have direct impacts on programs such as Medicaid and the Supplemental Nutrition Assistance Program (SNAP). A huge amount of Medicaid spending is borne by the states. As the states’ economies are challenged they turn to their available levers that can directly impact Medicaid spending.

Conditions that are untreatable today could well be treated in the future, which we see on a daily basis as new therapies are introduced. I am struck by the fact that patients I could not have cared for in the ICU when I was in practice, can now be cared for at home. The technological opportunities, advances in pharmaceuticals, and the long-term prospects for many of these treatment modalities could have significant spending effects, both positive and negative (think Sovaldi).

Massive treatment opportunities from investments in health care coupled with substantial costs to the system arising from those changes dramatically affects how we treat
How will innovation affect spending trends? Unsurprisingly, there are many developments, both in pharmacy and various technologies, such as devices that can monitor people at a distance, and improved telehealth opportunities.

the introduction of drugs, technologies and biologics. All of these initiatives taking place could have a positive or a negative impact on health care spending. What results will we see from the myriad demonstrations? Both the federal government, and the states to a lesser extent, have many available levers. The Center for Medicare and Medicaid Innovation is testing many strategies with mixed results. How aggressively will we adopt bundles, which will be mandatory, and what bundles do we create?

The states are increasing their use of managed care. Somewhere north of 70 percent of the Medicaid population is now under a managed care arrangement. The whole strategy there is to restrict choices and hopefully direct people to providers who are more capable of serving that population. There are clearly challenges, including finding ways to incentivize consumers to make better choices, improving value-based benefit design and value-based payment reform, and creating better incentives overall.

There is a host of questions around market competitiveness and efficiency. Much of the CBO spending trends are driven by price as well as utilization. How do we affect prices? How do we create incentives to choose the best treatments in terms of value and return? The antitrust and regulatory environments are critical and can change at any point in time. Many believe that ongoing consolidation has led to increased costs, raising the importance of understanding the future regulatory environment.

How will innovation affect spending trends? Unsurprisingly, there are many developments, both in pharmacy and various technologies, such as devices that can monitor people at a distance, and improved telehealth opportunities. But barriers remain for these innovations, many at the state level such as scope of practice—the ability of providers to engage to the full scale of their license.

Then there are the “hammers” of eligibility. Jessica suggested that eligibility is somewhat fixed, but this need not be the case. One can imagine a revisiting of Medicare eligibility which has occurred in the past for age and income. Obviously, there are great fears of turning Medicare into an income-related program. But in fact, we introduced means testing years ago for the treatment of premiums under Medicare. There is significant attention to whether Medicare’s eligibility age ought to be altered given what we now know about people’s survivability and how long individuals remain in the workforce.

I think there are many short-term and long-term tools and policy levers that are available, at both state and federal levels, which could have an enormous impact on our health care costs and how we perceive the system. From a congressional perspective, the challenge is the tradeoff between health and other programs. Do not lose sight of this reality about the Medicare constituency: people of this age vote! When you enter an election cycle, you focus on the constituents that are engaged in these issues, and they tend to be beneficiaries of the programs, particularly Medicare. The balance comes with trading off farm subsidies, or whatever it happens to be, with this escalation in health care policy.
HOW TO TRULY CONTROL HEALTH CARE SPENDING

Stuart Altman

It is always a pleasure to represent my younger brother. Here I was on a beautiful sunny weekend in Washington D.C. where I was to celebrate a good friend’s birthday. We were driving to his summer home in West Virginia when Paul Hughes-Cromwick sent me an email. He said, “Help!” How could I resist Altarum who has helped me many times in the past? I do not have any slides but that will not constrain me!

Several years ago, I got a call from a young reporter from the New York Times. She said, “Explain to me why health care costs are going up.” Since I am a professor and speak in 50-minute hours, I said, “Do you have time?” I proceeded to give her an absolutely brilliant lecture. I was quite impressed with myself. At the end of that presentation I casually mentioned, “When all is said and done, forget about costs. We talk about costs, but it’s spending. If you want to control health care spending spend less.” The next day, I eagerly went to see if I was in the paper. Sure enough there was a long article about why health care costs were going up, and there was one sentence of mine: “Professor Altman says if you want to control health spending spend less.” The next day, someone responded by saying that that was the dumbest statement he had ever read in The Times. Despite that reaction, I still believe it to be true. With all due respect to what has been said, if you want to slow the growth of spending we need to spend less.

I am an old creature of Washington. I gaze out at this youthful audience of analysts and I recall my Washingtonian youth. In the late 1960’s, when I was getting started in health care in Washington, there were maybe 20 people who had influence on health care. The big research groups, such as the Urban Institute and Mathematica, did not exist. (Indeed, I created the research group at the Urban Institute.) I managed to get big-time jobs. I was the first regulator for health care costs in the U.S., but I was not a health care economist because the field did not yet exist. Those of us in Washington thought we were the cat’s meow because we made a difference! I had a vague notion of the states, but we looked at their roles as trivial. We were in Washington and we made a difference. I do not want to burst your bubble, but you are increasingly becoming irrelevant working in Washington. What is happening in the delivery system and in the states makes an increasingly big difference.

We know what the federal government is spending on health care and we spend significant time analyzing this. However, if the federal government controls spending on Medicare, as it has been doing for the last 10 years, its impact on total spending is not nearly as great as it could be due to the great health care ATM machine in America called private insurance. Do you realize that the average hospital charges private insurance 100 percent more than what Medicare pays for the same services? Out West, at places like UCSF or UCLA, they are charging 150 percent to their private insurance to make up for the shortfalls from Medicaid and even parts of Medicare. All of us need to stop looking at the pieces of the health financing system and start looking at the whole puzzle.
What is happening in Washington increasingly makes my blood boil. All they worry about is what the federal government is doing. When you go to the states, all they are worried about is what they are spending on Medicaid. The truth is that we need to look at the total. There are a few states, including Massachusetts and Maryland, which are analyzing total spending. In Massachusetts, we created a law in 2012 that said, we do not want total spending on health care to grow by more than the growth in our state income. We also established the Massachusetts Health Policy Commission, which I have been chairing since its beginning, to be the searchlight to focus on how much we are spending, why we are spending it, and how we can spend less.

We created a blueprint or benchmark for spending with the goal of keeping spending growth no higher than 3.6 percent. The Health Policy Commission is like the health care system’s mother. We try to make sure they eat their vegetables and do the right things. While we have no direct regulatory power, any merger, acquisition, or major change in the system has to be reviewed by our commission. If we find that it has significant implications for higher spending, we can send it to the Attorney General and request antitrust action. We actually stopped Partners HealthCare, the largest and perhaps the most powerful health system in the world, from expanding in 2013. We are now reviewing another major merger and acquisition. Perhaps the most famous children’s hospital in America wanted to expand substantially. We—the Health Policy Commission—studied what were the potential cost implications of such an expansion. Ultimately the State granted Children’s Hospital a certificate of need, but included a requirement that the hospital report on its future pricing activities and put restrictions on how much it could raise prices. It also asked that the HPC report on what impact the expansion had on the availability of hospital services for children in other institutions.

This year, Massachusetts lowered its growth rate target from 3.6 to 3.1 percent. It seems to me that the Health Policy Commission is working to control health spending and costs. Massachusetts has gone from the most expensive health care on the planet to the second most expensive health care on the planet. More importantly, our growth rate from 2008 to 2014 was the second lowest in the country. This strategy is working.
QUESTIONS AND ANSWERS: PANEL I

Ceci Connolly
Thank you all. We have time for discussion and perhaps for a few questions. I will start with Sheila. You talked about alternative payment models and that Medicaid is now more than 70 percent managed care. To what extent are the problems of spending and poor outcomes due to the fee-for-service payment system?

Sheila Burke
I would posit, and I am eager to hear from Stuart, that it is a contributor to many issues, not the least of which is the incentive to do more to get paid more. I am old enough to have lived through the transition from cost-based reimbursement to Section 223 cost limits to prospective payment systems (PPS) to diagnosis-related groups (DRGs)—the whole movement. If you incentivize people to adopt technology, or to do testing, they will follow suit. You may be able to constrain the prices but then volume increases. As long as we have a fee-for-service system that provides for no real coordination, I think it will contribute to a host of the problems we are facing today.

Ceci Connolly
Stuart, do you agree and, if Massachusetts is making progress, are you succeeding by moving away from fee-for-service medicine, or is that still predominant?

Stuart Altman
Yes and yes. We literally threw the baby out with the bathwater in the 1990’s when we destroyed managed care and eliminated capitation. We need to move away from fee-for-service for the reasons Sheila pointed out. Massachusetts was, and probably still is, the leading delivery system in the country regarding adopting alternative payment systems. Our Blue Cross plan was the first major payer that went to an alternative payment system. I am not bragging, well, yes I am. We lead in this area, but that leadership has stalled. The percentage of our payments in alternatives to fee-for-service is no longer growing. Fee-for-service is still the dominant payment system in America and in Massachusetts. Unless and until we change that, we are going to have a difficult time controlling spending in a productive way. We could control it in the way government acts by lowering the prices, but that is not the best way to do so.

Sheila Burke
Agreed.

Ceci Connolly
Jessica mentioned baby boomers and I want to pick up on that topic because as we saw in your projections, and are all quite aware, many are living longer. Boomers tend to be pretty demanding. They want what they want here and now, and they want the latest and greatest. But at the same time, Peter Orszag shows an incredible chart of life expectancy in this country by income group. The truly appalling discovery is that, at lower income levels, life expectancy is actually declining. Moving up the income scale, life expectancy is soaring. How do you understand this? It is probably too late to address this issue for the baby boomers, but how are we as a nation going to attack this problem?

Jessica Banthin
I will speak to our projections first. What I presented included elaborate projections of demographics and aging over time. They also included our economic forecast and fiscal affects. Labor force participation plays a major role in our economic growth. We adjust for changes in fertility,
changes in mortality, and changes in immigration. Those three key factors affect how the population changes in size and age over time. Mortality has been, until recently, always improving. In fact, the projections I presented today still assume that mortality is improving. We are starting new work that would adjust mortality projections to account for this new data. Looking ahead, we have developed a Medicare model that analyzes a premium support plan. Congress is interested in this because it would take effect in the future and have budgetary effects that would play out even further in the future. That model goes out 20 years and represents an approach that we have been asked to refine, and that would encompass these variables.

Stuart Altman
With all due respect to Peter, there is cause and effect. My view is, and I think it is backed up by the facts, that the statistics you mentioned have less to do with our health care system and more to do with other aspects. We are learning how important the social determinants, the non-health care delivery issues, are for health. Most estimates suggest that health care contributes about 20 percent to the ultimate health of the population. What you see in low income populations is a whole slew of issues about where they live, what they eat, how they live, whether they have jobs, their mental health, etcetera, and these factors are extremely important for the health status of this population. I am all for giving people good health care, and I am appalled by those who are attempting to take it away, but we are not going to change these mortality outcomes unless we take a much broader view about what affects health.

Ceci Connolly
My journalist DNA compels me to see if I can get you to comment on last night’s news in the Senate and where in heaven’s name we are headed. Please, tell us.

Sheila Burke
I honestly do not know of anyone who was not surprised at the Senate failure of repeal and replace for a host of reasons, including the expectations that it was not going to be Jerry Moran (R-Kansas), or the conservative members of the Senate who would become the barrier in the short term. That may have occurred over the long term, but certainly more attention was being paid to the moderates. Senator McConnell is a remarkable tactician, and I cannot imagine anyone else being able to pull this off, but, I think the challenge has been the tradeoffs that pitted the moderates against the conservatives—a move in either direction ran the risk of losing folks on either side. That does not even take the House into consideration. The balancing act in the Senate has always been a very fragile relationship, particularly when the margins are as small as they are today. Recalling the January CBO estimates, those are extraordinary numbers of people that are likely to become uninsured under full repeal, approximately 32 million. Also, McConnell has a series of required items getting backed up. He has to deal with the debt limit, the appropriations process (either in a continuing resolution or bill by bill), all the routine authorizations, including defense, CHIP, and the usual Medicare extenders. The normal business of the Senate needs to proceed. The reconciliation instructions apply to this bill. You cannot do a tax bill under a new reconciliation instruction until you have dealt with health because you have to do a new resolution and give new protections to a new tax bill. Senator McConnell’s challenge is to get the business of the Senate moving but still have an established position to allow members to vote and enable them to go home to their constituents and say ‘I did my very best.’ Senator McCain’s last-minute illness created confusion. In my experience, having worked for the leader, delays are rarely a good thing. I think that complicated things. The moderates, Lisa Murkowski, Bill Cassidy, and others who had adjustments made in the final bill can go home to their constituents and say, ‘I worked hard to resolve your issues.’ But they will have to decide how to position themselves if they are challenged from the right.
McConnell is blessed by the fact that of the 33 senators up for reelection in 2018, 25 are Democrats (includes 2 independents who caucus with the Democrats). Dean Heller is the most exposed Republican. This is the balancing act that any majority leader must weigh. I was certainly surprised by the timing last night. What does Senator McConnell do next? If he pursues the simple repeal vote, can he get other business done and will he sit down with the Democrats to stabilize the market? That is the big question heading into the fall and the enrollment period: how do you stabilize the market?

Ceci Connolly

I am glad you mentioned that, Sheila, because the cost-sharing reductions are critical to the individual market.

Stuart Altman

Before I go any further, sitting next to Jessica, I want to thank you and your agency for the integrity and the quality of the work that you have done under tremendous pressure. I had a little to do with the 1974 law that created your agency and I have never been more proud. People may not always agree with the numbers, and as you pointed out, you are trying to project far into the future. With the possibility that the next act is going to be total repeal, I suggest you look at the CBO report from January 2017. The report argued that if you only repeal—remember you are not repealing the whole law, but only those aspects of the law that can be repealed under reconciliation—you will have the worst health care financing system this country has had since 1847. (I picked a number that I know nothing about!)

This would eliminate the funding and the subsidies, retaining items such as the mandate and preexisting conditions. It is a flat-out disaster. We have a President saying, “Why don’t we just repeal it?” But then again, Mr. Trump is now realizing health care is pretty complicated.

Jessica Banthin

Thank you, Stuart, for acknowledging our work. I am merely one of about two dozen staffers who work on health care scoring at CBO. In January 2017, we published an estimate of a delayed repeal of many of the provisions by the end of the window in 2026 that resulted in 32 million additional people uninsured. That is a combination of 23 million fewer in the non-group market, 19 million fewer people covered by Medicaid, and an increase of about 11 million in the employer market. That results in about 59 million uninsured in total. This is significantly different from about 28 million under current law. At the end of that period we estimated that the non-group market would be tiny. Only 2 million people would be able to find coverage in the non-group market because it would be difficult to sell policies with guaranteed issue, prohibition on preexisting condition exclusions, and other restrictions.

Ceci Connolly

We are running out of time, but I see Marilyn at the mic.

Marilyn Serafini

In Jessica’s slides, Medicare looked monstrous. At what point do we begin to address its growth? What is the moment that compels us to take action?

Sheila Burke

Everybody took a deep breath when the 2017 Medicare Trustee’s report came out. The Independent Payment Advisory Board (IPAB) was not triggered, and it was not as bad as expected (2029 is a long way off so why worry?!). I do not think there is any less interest in addressing the underlying issues of Medicare. Certainly, Speaker Paul Ryan feels strongly about looking at issues such as Medicare premium support. I assume he will continue those efforts. Work continues to change the reimbursement system. Efforts will likely continue on the fundamental issues of Medicare such as age and eligibility. We will continue to struggle as The Centers for Medicare & Medicaid...
Innovation (CMMI) test new methods, including value-based reimbursement. But I see nothing radical for the Medicare program in the short term. Think about the amount of time it took from the beginning of Medicare in 1965 to when we did anything different. The drug benefit is the single biggest change we have had. We tried catastrophic, which was a crash and burn affair. Changes in Medicare come very slowly. I expect these conversations to proceed, and that Speaker Ryan will continue to pursue changes on the basis that we have to deal with this over the long term.

Stuart Altman
Marilyn, I am going to get in trouble with this audience, but I will tell you the truth! There are not too many of you in this room on Medicare besides me. Despite what you have been reading from the Medicare Payment Advisory Commission (MedPAC) and others, it is getting increasingly difficult to get a primary care physician if you are in an upper middle class community. I have lost three primary care physicians in the last five years. I have given up. I, like many other people who are not rich but not poor, am going to concierge medicine. Six months ago, the Mayo Clinic announced that it was going to give special services to people with private insurance. I reluctantly predict that if the federal government continues down its current road, where it controls only the prices paid by Medicare because it cannot control utilization, Medicare is increasingly going to look like Medicaid.

Marilyn Serafini
That is at odds with what Sheila was saying about the need to focus on primary care.

Stuart Altman
I love Sheila, but by the time she gets to Medicare, and by the time you get there, you may not like what you get.

Sheila Burke
Actually, I am there. Let the facts show.

Stuart Altman
As far as I am concerned, you are still twelve years old.

Sheila Burke
God bless you. What I hear from Stuart’s comments is this growing drumbeat around moving to a single payer, to a set of rules that treat all payers in the same fashion. Maryland has done rate setting for years. Massachusetts has made a very serious effort to engage all the payers and move towards a common system. That may well occur. But the federal focus, at least in the near term, is surprisingly not on Medicare or the federal exposure. You are absolutely right, Stuart, that there is a declining number of primary care physicians. That is as much of a workforce and training issue as it is a Medicare payment issue. We have had that problem for years in Medicaid where we have a relatively small percentage of physicians who are willing to take Medicaid patients. I was mentioning to Jessica that there was an article about the Cleveland Clinic terminating their Medicaid contract. There are many services that Medicare does not cover. Relative to the social determinants, Medicare is worse than Medicaid in its willingness to look at community-based care.

Ceci Connolly
Marilyn, you opened a real can of worms here and we are over time. I know we could keep going with this group on these topics, but please join me in thanking our panelists.
Anne Montgomery

I am Anne Montgomery, Deputy Director of the Center for Elder Care and Advanced Illness at the Altarum Institute. I am grateful to the Robert Wood Johnson Foundation and my colleagues, Paul Hughes-Cromwick and Ani Turner, for assembling four star-studded panels. The remarks by Jessica, Stuart, and Sheila were incredibly thoughtful. I took a lot of notes and I have many questions.

This is definitely a fraught time in health care. The debates about health care reform seem to be around us all the time. They have been front and center on the national policy and political radar for most of my career, and well before that. I would wager, and I always have a 50 percent chance of being right when I make predictions, that an intense level of debate will continue, because not only is health care personal, even existential, it is also very important to the federal government and deeply intertwined in state economies. Also, public financing contributes heavily to the physical infrastructure in which practitioners work. Our hospitals and doctors offer some of the best health care in the world, albeit with the gaps Sheila referred to, and it is a safe bet that no one wants to see that deteriorate.

These factors offer strong arguments for working across the ideological spectrum. Drew Altman, who could not be here today, wrote a terrific column drawing on survey data that shows public support for bipartisan work on health care reform. While that has not happened so far, I think there is a growing chance that it could. Personally, I think that would be awesome and I think everybody on this panel would agree.

In that spirit, this panel will focus on long-term care in a bipartisan way. Although policymakers are not explicitly talking about long-term care, it is an important subtext in Medicaid discussions. One of those subtexts is that with the boomer generation steadily aging into Medicare, the question of what Medicaid can cover regarding long-term care services is looming ever larger. One hypothesis we will advance in different ways on this panel is that if we ignore long-term care, or if we are not creative about how to cover it more reliably, we will make insufficient progress on taming overall health spending.

Figure 1 provides a snapshot on long-term care costs. This was prepared by the Kaiser Family Foundation and the data are from Genworth. The bottom line is that long-term care is expensive, with nursing home costs leading the way at nearly $100,000 a year. These costs are very high and affect both families and government programs.

We are accustomed to thinking of Medicaid as the major payer of long-term care costs. Yet, analysis by the Urban Institute and others show that private out-of-pocket costs...
like to give sweeping answers in phone interviews. In this case, however, voters recognized that long-term care is a major problem and there are not many good answers being advanced—yet.

To change this, the second hypothesis I will advance is that to make quick progress we should look at adapting existing programs and models of care and combining medical services and long-term care in a rational continuum. This is what we have been working on at the Center for Elder Care and Advanced Illness, and I think of our model as pulling long-term care into our health care system for seniors.
The six puzzle core components can fit into existing Medicare programs. To appreciate this puzzle, first you identify the long-term care cohort within Medicare—frail elders who have two or more limitations in ADLs. Second, you assess and create comprehensive longitudinal care plans that comprise the full range of medical and long-term care needs, taking into account the very different quality-of-life goals that people have at this stage of their lives, and their treatment preferences. Third, you adapt the medical services to reflect good geriatric care, which pays much more attention to things like eyes, ears, mobility and the ability to function on a day-to-day basis, with somewhat less emphasis on aggressive curative care, unless that is what an elder wants. The model focuses on avoiding hospitals and nursing homes as much as possible by providing lower-cost, preventative, upstream services.

Fourth, there is explicit addition of long-term care support services to the service delivery continuum. Fifth, you lay the groundwork for development of a population health approach. This means a system that looks across all similarly situated elders in a given area by establishing an independent community-focused board that can guide and shape the types and availability of services. And sixth, once high-cost, low-value services are decreased, the resulting savings are returned to community providers to help buttress local long-term care services which tend to be underfunded.

How well does this work and how would it impact spending? We investigated this by modeling projections in four very different communities: 1) Akron, Ohio; 2) Milwaukie, a suburb of Portland, Oregon; 3) Queens, New York; and 4) a rural area outside of Williamsburg, Virginia. The nitty-gritty details are in a Milbank Quarterly article we published in 2016. Here is the shorthand version:

Find providers who have desire for change and reform to create a more rational coordinated care system for frail elders in a given community using existing public program revenues, and including individuals with private pay resources.

Generate methods of enrollment for the target population—specific to the local area you want to cover, that needs both medical and long-term care.

Construct baseline cost estimates for each major service area from inpatient hospitalization through lab services, primary care, durable medical equipment, vision, dental, long-term care and more, along with utilization for these services.

Establish conservative estimates of the projected savings you are seeking that are grounded in the literature, and include expected enrollment of the target population as the program is ramped up (Note: local providers need to agree on/buy into these savings estimates as realistic targets).

Build in administrative start-up costs—for example, provider training, marketing/consumer activation, development of standards and operating protocols.

Calculate and track savings from the reforms that are implemented, which will be realized mainly through changes in the utilization of certain services, rather than through price changes.

Figure 5 shows the projected per-beneficiary, per-month savings we calculated in the four communities over three years.
years, which range from $125 in year one in Williamsburg to $537 by year three in Queens (a high spending, traditionally fee-for-service-dominated area).

Figure 6 shows that, as enrollment increases, more appropriate care is established, and startup costs decline. Savings are $328 per member per month (or 5.4 percent) by the third year in Akron. The return on investment there (net savings divided by total expenditures) is 289 percent over three years. Very attractive returns even while we were very cautious in extrapolating possible savings from reduced high-cost, low-value care.

Where can we apply this concept? The most obvious place is the Programs of All-Inclusive Care for the Elderly (PACE), which is currently calibrated for dually eligible beneficiaries. We are arguing the case, and we are not alone, that PACE should be expanded, scaled, and rapidly adapted to achieve these ends and become a major Medicare provider. We think this is mostly possible within current regulatory authority. We are also excited to see that the Senate is moving forward with the Chronic Care Act (S. 870). When enacted, which I think will almost certainly happen this year, the policy will make it much more possible for Medicare Advantage plans to target long-term care supports to their enrollees who need them, within current resources.

For those who are intrigued and want to know more, we wrote a book entitled “MediCaring Communities: Getting What We Want and Need in Frail Old Age at an Affordable Cost,” that lays out the case in detail. The primary author is my colleague and the director of the Center for Elder Care and Advanced Illness, Joanne Lynn. She is here today and I am very proud to have contributed to the book.

I will now hand off to my amazing colleagues. Since their bios are long and distinguished, I will keep the introductions brief. Rodney Whitlock served as a longtime Capitol Hill staffer with Senator Chuck Grassley and Congressman Charlie Norwood, and has written many health care provisions into federal law. Hemi Tewarson, a Medicaid and health policy expert, is Division Director at the National Governors Association Center for Best Practices. John Cutler is an expert on private coverage, having played a principal role in designing the federal long-term care insurance program for federal employees which, I believe, is still the largest private long-term care insurance plan in the country.
INTEGRATING LTSS INTO MEDICARE FOR INDIVIDUALS OVER THE AGE OF 65

Rodney Whitlock

I am going to stimulate your thinking with a little brain candy today. My presentation is based on work that I have done on how we could change policy if our goal was more efficient ways of structuring how we pay for services to actually benefit the individuals involved, and perhaps be better for the taxpayer. Absolutely radical stuff, I know!

Many people are deeply concerned about the long-term effects of health care spending on the budget, particularly those who put R’s behind their name. But I can solve that problem. I can write that bill. It is relatively easy to do. Simply go into the statute and write “minus 10,” and you will save 10 percent across the board. Stakeholders will burn the place down and you can never pass that bill, but it is easy to write. If, however, you want to make structural changes that increase efficiency, you have to look at the system differently. You cannot treat it like a puppy. ‘Go on the paper, damn it, I told you go on the paper; Medicare, be more efficient, just be more efficient!’ It simply does not work that way. Instead, you must look at the way the programs are structured, ask hard questions, and develop different approaches. That is what I am going to talk about today.

As you are all knowledgeable about our current system, I will breeze through this overview. We deliver care through separate systems. Medicare covers acute care (physician visits, hospital stays, post-acute skilled care, and prescription drugs), while Medicaid includes wraparound services, particularly financially, and provides long-term services and supports (LTSS). Between the two programs, there is a lack of coordination as well as incentives for cost shifting. As a result, we have poor outcomes and increased spending. We do this every day and act shocked that we have this as our outcome. But again, we are not able to yell at it to be more efficient and expect it to do so. The outcomes are a function of its structure.

How do those over the age of 65 obtain LTSS in our current system? Many are self-funded, using life savings. You have heard the old line: in America, our long-term care insurance policy is Medicaid, and the deductible is your life savings—come to us when you are half dead and broke, we are here to serve you! Many rely on family. The concept of the family caregiver is part of our DNA for LTSS. Others “spend down” to Medicaid eligibility. I have four grandparents and three have done so. Finally, we have a radical concept of private insurance. When we survey the take-up, we find penetration is usually in the single digits. Again, this is not an efficient system.

Let us talk about spending. In 2012, Medicare and Medicaid spent $187.0 and $118.8 billion, respectively on dually eligible beneficiaries. Medicaid is spending $42,000 per person, or 50 percent of total Medicaid spending, on dually eligible beneficiaries. Home and community based waiver services (HCBS) per person spending was $30,000, or 24 percent of total Medicaid spending for duals. There is a lot of money here!

It is only logical when we consider budget prospects, to consider cutting in places where there is a lot of money. This is clearly a ripe space to go “minus 10,” and anyone working in these industries knows it. Policymakers who...
lack the understanding of how to make it more efficient are prone to say “minus 10, we have solved the problem.”

**Figure 1** shows LTSS spending by payer. Clearly, an area with little use is private insurance. People do not prefund LTSS like we do for other insurable events. You insure your life against death, your health against sickness, your home against catastrophe—I had a lightning strike on Friday, so I know all about that one now—and your car against an accident, but **not** your long-term care. This typifies the nonsensical approach we have about the elderly part of our lives: when you turn 65, your pathway toward the end is a long, fulfilling retirement where you are able to do everything you want until your last day when, surrounded by family and angelic music, you move on to the next realm. You will never have to spend any time in a hospice, long-term acute care hospital, skilled nursing facility (SNF), HCBS, or require acute services for a chronic care incident. This is our approach which is why we get the outcomes we do.

Let us rethink this entire concept. How would we consider this differently for individuals over 65 years of age? I will use an analogy of drugs compared to LTSS. We approach prescription drugs in the Medicare program as built around the concept of intensity of utilization. When my dear friend David Nexon, who is in the audience today, was writing a bill 14 years ago, the idea that you would be worried about people who are utilizers versus non-utilizers would be a crazy way to build a benefit. Of course seniors use drugs. One should build the concept around the intensity of utilization. This applies to LTSS as well.

Reviewing the history of how the Congressional Budget Office looked at this issue when considering Part D, they used the concept of the cost reduction factor. Their general rule was that financial risk incentives control cost. The incentives for cost management were:

- Providers: full-risk bearing plans versus limited-risk bearing plans
- Beneficiaries: exposure to financial risks determined by premium level/cost-sharing—will, in turn, affect competition among plans.

Compared with traditional indemnity insurance plans, Part D achieves savings through:

- Negotiating price discounts or rebates from drug manufacturers and pharmacies;

**Figure 1.**

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**Percent of LTSS Spending 2015 by Payer**

- Controlling overall drug use; and
- Changing the mix of drugs used to affect intensity of utilization.

That is what you need to do in the LTSS space instead of treating it like an indemnity plan, where it pays out as you pay in (as you utilize) making it impossible to control intensity of utilization.

You can look at it two ways: catastrophic versus comprehensive. Catastrophic coverage is an old idea, where people gain access after they hit a certain threshold. It is easier to control costs to the taxpayer in a catastrophic coverage approach, but the ability to control intensity of utilization is much more challenging. That is where a comprehensive coverage approach has an advantage. It has the ability to control costs across the continuum of care, that is, a higher cost reduction factor. The tongue-in-cheek phrase is hangnail to hospice, cough to coffin.

Having a unified payer responsible for all services is the most efficient structure for the provision of Medicare and Medicaid services that require coordination between programs. One payer needs to be in control of individuals for all their care needs at risk and with assignment.

How would a model to create LTSS coverage for all Medicare beneficiaries work? You have competing private plans offering a product that covers everything—Parts A, B, D, and I will go ahead and trademark “Part E.” I got that letter; it is mine! We will call it Medicare Extended! I am trademarking that, too. (I work in a law firm now, I have people who can do that for me!) The private plans would
set premiums to spread risk across all beneficiaries, both the healthy and the sick, across the entire continuum. They would then have extremely strong incentives to manage the care and cost of the beneficiaries, particularly those at risk of needing LTSS.

How does Medicare structurally view LTSS utilization? It does not care; it is not paying for it. Think about the frail elder who can stay at home for six to nine months through grab bars, alert devices, home-based services, Meals on Wheels, and other services. Compare that to the cost of a SNF. There is no question which leads to a better outcome. It is cruel to say, but true: Medicare is not structured to care about that outcome. You cannot change this without changing the system.

My dear friend Connie Garner and I wrote a piece that highlighted four key principles for providing the most efficient care. We have since added a fifth that someone suggested to us.

▲ For the system to work, there has to be care across the entire continuum.

▲ Providers must be at risk across the continuum—it does not have to be insurers, it can be health systems or anyone who wants to bear risk. But with risk comes the consequence of producing outcomes.

▲ The system needs assignment—beneficiaries need to know what plan they have. Medicare was built on the idea that people could see whoever they want. Today, people turning 65 have not lived that life in a generation or two. They appreciate the notion of network coverage. The concept of ‘go see anybody you want’ dates back to 1965 and is no longer relevant.

▲ We need full availability and participation, meaning we need everyone in. Everyone needs access, but everyone needs to be in as well. There can be no exit ramps, no showing up when care is needed. Medicare encourages all people to participate, a system like this should do so.

▲ It only succeeds with quality measures that prove that those who are bearing the risk are trying to achieve the best outcomes, not cost avoidance.

It is critical for this model to have a uniformly agreed upon assessment to determine functional eligibility because that is the gateway to the entire conversation. In order for the system to function, we also need to set up a series of controls. First, as already mentioned, we require all Medicare beneficiaries to participate. Second, we have to move away from the anachronism of fee-for-service that has existed for 50 years. In the last three to four years (under a Democratic administration), the Centers for Medicare & Medicaid Services at the U.S. Department of Health and Human Services targeted this goal. This is not a radical idea. Medicare as we know it is on its way to a transition. Third, the three R’s, risk adjustment, reinsurance, and risk corridors, are critical to any process such as this. They are needed to make any risk-bearing arrangement work (while I understand this view is not currently in vogue). Finally, income-related cost sharing, which is already part of our Medicare fabric, needs to continue and be broadened.

How is this model an improvement? Fewer individuals will enter Medicaid through the spend-down eligibility category, which is borderline obscene. It increases access so that people can get care before they need institutional utilization. This would be a system into which everyone pays and prepays for services, instead of our current system which says, “Hey, are you half dead? Are you broke? Come see us!” Finally, because of strong incentives, it has the potential to improve quality of care and ultimately reduce costs.

I know my brain candy is radical stuff—a restructuring of Medicare and Medicaid. There are pieces for all sides to hate. Conservatives will call it an entitlement expansion. Liberals will say it is a privatization of Medicaid. But, being dispassionate, this is an idea to provide efficient care and save money through a more efficient redistribution of dollars already being spent in arguably indefensible ways. With all that has happened over the last six months, is this all that outlandish, especially when compared to the more arbitrary proposals being floated?!
Hemi Tewarson

Good morning, everyone. Rodney is always a hard act to follow, but I will do my best. I am the director of the Health Division in the National Governors Association (NGA) Center for Best Practices. I am here to represent the states, to speak from a Governor’s and their team’s perspective about how we consider LTSS, how important it is within the conversation of health reform, and what ideas we are pondering to make progress.

A bit of background on NGA (Figure 1). We are the oldest organization serving the interest of the Governors. We are completely bipartisan and accept all members. Our current chair is Governor Brian Sandoval, a Republican from Nevada who actually expanded Medicaid, and our vice chair is Governor Steve Bullock, a Democrat from Montana who also expanded Medicaid. I am emerging from three days of the NGA summer meeting where health care was the major topic of conversation. I bring that perspective here because we have been discussing what states should be doing about health care, and how LTSS plays a critical role in that.

NGA has two parts: the NGA government relations group, which is the lobbying arm to Congress, and the NGA Center for Best Practices, which is where the health division is, and where I sit. We work to develop evidence-based practices, either from other states or other models that governors and their teams should consider implementing in their own states. Our job is collaborating with them on different types of projects, and to make the work actionable. Everything we are discussing in this symposium is complex—a lot of theory and hypothetical actions that could be adopted. Our job at NGA is to take these ideas and actually help states adopt and implement them.

We try hard to break down silos in our work. I was happy to hear discussion about social determinants of health in the first panel. Thinking about other health-related needs and how we can bring resources together to effectively address them is very important for our LTSS discussion. This is what we try to do in our projects with governors and their staffs.

States have much to consider these days. This includes not only the ideas that are coming out of the U.S. House and Senate, but also in their own legislatures, especially how to make their programs more efficient while improving care for their populations. There are many different approaches and states have been trying various initiatives. Some have been triggered by incentives within the Affordable Care Act while others result from their need to balance their budgets every year, plus the ongoing requests from the populations they serve.

We organize our work into six focus areas, which are, of course, not mutually exclusive:

▲ Health systems transformation;
▲ Medicaid and health insurance coverage;
▲ Workforce, which is an important element for LTSS to have sufficient workers to provide the care we need across all states;
There has been solid progress on rebalancing at the state level, to move away from institutional care towards home and community-based services (HCBS). A survey last year showed that, for the first time, over 50 percent of services are on the HCBS side. While this is clearly a sign of progress, more is needed since the results vary substantially across the states. We are focused on improving this at NGA.

In addition to rebalancing efforts, states are considering many ideas to better serve this population. One is innovative delivery models. Another idea is Managed Long-Term Services and Supports (MLTSS). Seventy percent (and growing) of the Medicaid population is in managed care. Some states feel that managed care could be a better way to coordinate services across the spectrum of health, including physical, behavioral health, and LTSS. Virginia believes strongly in this approach which I will discuss below.

Other ideas being explored by states include targeted solutions for unique populations, such as the dually eligible, or those with developmental or intellectual disabilities. States such as Washington are looking at caregiver supports and I will also discuss their model, under a waiver program, below.

We developed a set of shared priorities at the June meeting. Our diverse group of 13 states was very interested in how to address the aging population and LTSS. I hope this is the start of a conversation that has traction and will promote work on a bipartisan basis. I will discuss a few tidbits from the larger document which is available here.
The first priority is additional flexibility and support for efforts to improve the quality and value of LTSS, for example, creating an expedited process by which states could decouple nursing facility criteria from eligibility for HCBS. For many LTSS programs, such as the HCBS 1915(c) waivers, the individual has to be eligible for nursing facility services in order to qualify for HCBS, which is a high level of care. But, sometimes states want to provide HCBS at a lower level of care before that person needs a higher level of care. There is also serious interest in learning how to make care more accessible via innovative approaches to eligibility, to slow Medicaid spend down.

A second priority is continued federal support and investment to help states maintain and build on payment and delivery system reforms that derive greater value into the health care system. We must do a better job caring for the dually eligible. There has been some progress in creating a dually eligible office, but from a state perspective, that office could have more power and better integrate the two populations. Two examples are to provide more Medicare data and to think about shared savings opportunities. If there were programs that allowed savings on inpatient utilization or emergency room visits to accrue to Medicare, the Medicaid program could incentivize those changes and share in those savings to have a more comprehensive approach to move to a better delivery system.

The last priority is flexibility to cover evidence-based services that improve health outcomes and provide a return on investment by addressing the social determinants of health. This is obviously broader than the aging population but I think it has value in this context as well. People can have access to meal preparation and other support services at home through the HCBS waivers, but we can take it a step further. States are looking towards a more holistic approach and being more creative in determining how to build reimbursement for nontraditional support services (beyond the medical services in their Medicaid contracts) that can then lower acute care spending.

I want to turn to the Washington and Virginia examples. In Washington, we helped them with their waiver which was recently approved. Medicaid Alternative Care is an innovative idea that they are very passionate about and believe it will make a big difference. It offers an alternative limited LTSS benefit package to those who are Medicaid eligible and at least 55 years old, targeting people who are not currently using LTSS. It is designed to support the unpaid caregivers to allow people who are receiving caregiving support in their homes to remain there and not have to access the more expensive LTSS services, whether it be full-blown HCBS, or going to a nursing facility. They can switch into the traditional benefit at any time if they need it.

Another component provides a benefit package to a new eligibility group Tailored Services for Older Adults (TSOA). It is offered to those at least 55 years old who are not yet eligible for Medicaid. The benefit package is again targeted to support caregivers, but is designed such that patients do not spend down as quickly to the full package of more expensive Medicaid benefits. The types of services being provided in this program are caregiver assistance, caregiver training and education, specialized medical equipment and supplies, health maintenance and therapies, and personal assistance services. The cost of the package is $550 per member per month (PMPM), compared to $5,200 PMPM for a nursing home, or $2,000 PMPM for home care. The state expects approximately 8,000 individuals for initial enrollment, with the majority in the TSOA program. They expect up to $23 million in annual savings by year four of the program. The state believes this program will make a significant difference in allowing people to stay in their homes and also save costs.

Virginia has a different approach called Commonwealth Coordinated Care Plus. They are innovating through managed care by implementing a mandatory MLTSS program for about 213,000 individuals. Rodney mentioned the need to coordinate care more broadly. This is Virginia’s attempt to do that. They will go statewide in 6 regions with 114,000 duals and 77,000 developmentally disabled individuals, with the health plans varying by region. The goal is fully integrated medical, behavioral health, and LTSS, with an emphasis on care coordination and person-centered care using an interdisciplinary team approach. They will coordinate the Medicare benefits through a Dual Eligible Special Needs Plan (D-SNP), and the continuity of care period is 90 days.

Virginia is hoping to see a difference in spending due to the emphasis on coordination, but only time will tell. We eagerly await the results of this. I will note that MLTSS is not a solution for all states. Virginia feels that it is the logical step for them. Other states are in different policy places. But, many states are interested in this model and looking for the results in Virginia and states following similar strategies, to determine whether it is right for them.
Beyond the ACA: Long Term Care in America Over the Next Five Years

John Cutler

For those of us who work on long-term care, we are always glad to be included in a health event such as this because the seats are full!

I want to begin by recognizing that long-term care (LTC) is obviously concerned with issues besides financing. There are interesting developments with service delivery, including moving beyond traditional nursing homes, mostly dominated by increased reliance on assisted living facilities. There will be future challenges regarding the paid and unpaid workforce in providing LTC, that is, how many service workers there will be. There are also significant issues surrounding caregiving, but there seems to be bipartisan support and I expect congressional activity in this area.

But this discussion is about financing. Private long-term care insurance (LTCI) penetration looks like what Rodney showed in his pie chart. However, those of us in the private insurance industry calculate this percentage a little differently because there is an issue of who should be included in the denominator. You have to be at least 18 years old and you cannot be on or near qualifying for Medicaid, because it would be unsuitable to sell LTCI to someone who might spend down to Medicaid. Thus, we say the percent with LTCI is about 10 percent, but, for those age 65 and older, about 16 percent have LTCI. This rate is a little higher than often suggested and does provide some solace to those holding it out as a solution.

Other private sources of LTSS funding include people’s life savings, home equity, and life insurance. We call these sources “point in time” products, because they are used by people who do not have LTCI but suddenly need a way to pay for care, such as a nursing home. We do not have a good individual safety net for LTC needs. People typically have to rely on whatever income and assets they have at the time.

Public sources of LTSS funding include Medicare (post-acute only), Medicaid, and others, such as the Veterans Administration.

Anne mentioned that I was the architect of the federal government’s LTCI program. We began the program in 2002, but evidently, we promptly killed the market because it did not go anywhere! The traditional LTCI market has been stable or shrinking since then with most carriers exiting the market. But insurance companies are not about to become extinct without a fight. There have been interesting innovations in the way that the LTC insurance companies have tried to address the problems with their products.

One such innovation is to offer short-term policies that provide one year of LTCI protection compared to “true” comprehensive coverage. This product has received some philosophical support. For example, the California Partnership has always required insurance companies to sell a one-year policy, because one year is better than no coverage. But I honestly do not know where this will go. If people are not interested in buying LTCI, will cheaper products be more attractive? If the barrier is not price, but instead their willingness to buy any LTCI product, then this strategy may not work. The National Association of
Insurance Commissioners (NAIC) is now developing new regulations on this type of product.

The other diametrically opposed innovation is adding life insurance (or annuities) to LTCI. The idea is that since people do buy life insurance (though annuities not so much), maybe they will also buy LTCI in a “combo product.” These products are slightly more expensive because companies are insuring two risks. We will see how well they do, but, of course, for those not interested in life insurance, this brand of LTCI will also fail.

A common theme of the ongoing discussion in Congress and among Governors is the desire to accelerate state innovation to save money. A well-known idea is state block grants. When I sent my slides to Anne she said, “You’re not in favor of block grants, are you?!” My answer is probably no. The two motivations for block grants are to save money on the federal side, and to give states more flexibility to innovate. But, how many states think they lack the authority to innovate now? Some states are already successfully innovating. It seems like the Obama administration accepted every waiver request they saw. But some states are clueless. They will never innovate, whether it is the previous administration or the current administration. They would practically have to be forced to act, which is hardly the definition of state innovation. Even if states do innovate, will they be able to include LTSS if there is insufficient funding? Those of us who study LTC assume that the other core constituencies of Medicaid, such as women and children, would suffer regardless of what happens with LTSS spending.

Reforming Medicaid is not only about money and state innovation, rather, it is about delivering a better product that goes beyond medical services. More effective mechanisms can be built into Medicaid with financial incentives for states to undertake cost-effective initiatives to create improved access to housing or enhanced supports for family caregivers. Infrastructure investments should include housing that is suitable for lifelong use, which will save money for the health care sector over time.

There are several groups developing interesting proposals to reform Medicare, and they are taking different approaches:

- Altarum’s MediCaring Communities, as well as the National Academy of Medicine’s proposal, aim to make Medicare better through improved coordination of care and delivering services beyond health care for those with chronic conditions and functional limitations. Medicare is a health insurance program, but is missing these other services.
- The Chronic Care Act (S. 870), which came out of the Senate finance committee about a month ago, aims to allow Medicare Advantage plans to cover home care and other supportive services (for example, personal care, transportation, and nutrition services), for targeted enrollees—not only medical care.
- The Bipartisan Policy Center (similar to the Minnesota Department of Human Services, a client of mine), which introduced their proposal last week, seeks to add home care to either or both Medigap and Medicare Advantage plans.
- The Commonwealth Fund’s “Help at Home” proposal is comprehensive LTC coverage that includes a payroll tax to finance it.
- Congress has begun to address expanding the Program of All-Inclusive Care for the Elderly (PACE).

There are other federal options to enhance LTSS financing. Congress could remove restrictions at the federal level that are barriers to insurance solutions: revise Medicaid “Partnership” LTCI rules to lower the inflation requirements from its inordinately high five percent; allow the NAIC to more easily approve new policy types under HIPAA law (to deal with the nexus between state authority and federal law); or create consumer-friendly Medigap-type coverage that is affordable and available online.

We could also change tax rules to allow better use (“repurpose”) of existing health and retirement products. I love the idea of being able to tap into 401(k)s and IRAs more efficiently for LTC needs. Another example would be

More effective mechanisms can be built into Medicaid with financial incentives for states to undertake cost-effective initiatives to create improved access to housing or enhanced supports for family caregivers.
to explore Health Savings Accounts (HSAs). Yesterday, the Employee Benefit Research Institute said that people are using HSAs like savings, rather than as investments. They are paying copays and deductibles and not actually moving money into the future. The only way an HSA would work for LTC is if one moved large amounts of money into the future and refrained from using it on current health care costs. There would need to be a LTCI-specific HSA.

Finally, we could provide additional tax breaks for LTCI. I am not a fan of this approach because it has not shown to increase take-up. It ends up only redistributing money to higher income people. If you implemented a tax break, it would have to be a credit, rather than a deduction.

There are a number of promising developments happening in various states. In Minnesota, they have been emphasizing LTSS financing reform since 2012, joining the ranks of states educating their population via the “Own Your Future” campaign (which goes back to the Clinton administration).

More interestingly, in the absence of a robust LTC insurance market, the state has decided to initiate new product development. One product is a “life stage” product, which is a life insurance policy that converts to LTCI at retirement. Another product, which is the one I am working on, is a home care benefit embedded in Medicare Advantage and Medigap plans. Ideally, these home care benefits would be embedded in Medicare itself, where it could reach all beneficiaries. While Minnesota cannot control Medicare, they can influence these supplemental plans, which reach about 75 to 80 percent of Medicare beneficiaries.

Washington State has passed legislation to fund a study on the feasibility of new LTSS financing options that would include a public mandatory LTSS program, as well as a public-private approach where the state would assist in funding catastrophic coverage to help stimulate the private insurance market. Funding would be through a payroll deduction that could provide a one to three year, capped-dollar LTCI benefit. Additionally, there could be a public-private reinsurance or risk-sharing model where the private insurer would be the primary risk bearer.

Hawaii considered pursuing a comprehensive, universal LTC program in 2014, but changed course when they realized they were being overly ambitious, and began an inexpensive education campaign. In 2016, they decided on a caregiver support program for those working full-time who need respite care. The program gives workers a small, daily dollar amount to help cover the costs of their dependents’ care. The goal of the program is to help working caregivers stay in the workforce, instead of being forced to quit their job or cut back on their hours. As of last week, this was signed into law by Hawaii’s Governor and will be paid by general revenue and limited in terms of the number of slots available.

California is among a dozen states participating in national demonstrations to improve care for people with serious chronic illnesses and functional limitations who are dually eligible for both Medicaid and Medicare. The program, called Cal MediConnect, will integrate the full range of Medicare and Medi-Cal (California’s Medicaid program) services, including LTSS and behavioral health services. Cal MediConnect is part of California’s larger Coordinated Care Initiative (CCI), which includes a mandatory enrollment of dual eligibles into Medi-Cal’s MLTSS program. I will point out that there are issues for dual eligibles in these systems because Medicare typically allows people to go to any doctor or hospital they want, but managed care does not. It is yet to be determined how that will work out. But, I give California credit for spending significant energy on the duals and trying to change the dynamic around LTSS.

Looking at the more conservative states, their approach is typically educational programs and initiatives to stimulate the private market. Indiana has legislated a study on LTSS where they hope to raise awareness about LTSS need, offer innovative and affordable tools and options for people to prepare and pay for LTSS, and to protect the future of the Medicaid budget by shifting funding to private sources.

Nebraska has created a task force to foster financial independence through private market incentives and better manage state resources. These states are behind the curve set by states like Minnesota and California, but it is important that they are paying attention to these issues.
Anne Montgomery
With little time remaining, I will take the moderator’s prerogative, and ask a question. You can tell we are a panel of optimists here! We believe that reform is entirely possible. I ask you all to put on your prediction hats and give me your thoughts about opportunities to work across the aisle, be bipartisan, and incorporate some of these ideas into a health care package, a tax package, or at least get them seriously considered.

Rodney Whitlock
No! Are you are watching the same thing I am? More seriously, it will require some stepping back and finding a more comfortable, objective place to engage health care.

Hemi Tewarson
I do not think anything will happen this year. Our hope is, if the current version of the Senate bill does not move forward that there would be interest in bipartisan ideas on the private market side because that is the more emergent situation for states. I did not mention in my remarks that two of our policy priorities focus on cost-sharing reductions and federal reinsurance programs. These ideas need to be addressed in the short term. I do not know if there will be the appetite for taking on some of these LTSS issues. It would be wonderful if there were, but being pragmatic, I am not sure that legislators will have the energy or the time to do that.

John Cutler
I tend to agree. We do know, however, that there is interest in moving forward with a tax bill. One thing that might happen is that members could insert some of these ideas on the tax side.

Melissa Habedank
I am the director of a network of federally-qualified health centers (FQHC) in the San Francisco Bay area, and I want to introduce a challenge that we are experiencing, which is related to what you have addressed today, and also pose a question. Our patient volume has grown 650 percent in the past 15 years, and we are opening a new center every other year to absorb demand. The public is our primary payer. We all know that high-quality interdisciplinary prevention programs are critical to get the return on investment that we are hoping for, and to do right for our patients. I appreciate that speakers have stressed the importance of social determinants of health. I formerly chaired a committee at our FQHC that was redesigning our care delivery model to include not only a primary care physician and medical assistant but also a care coordinator and behavioral health provider. The behavioral health provider is an associate social worker, which is not reimbursable by Medicaid; neither is the care coordinator. When we are...
talking about patients that have complex illnesses and chronic needs it is important to have those nontraditional service providers work alongside the provider. When they are not reimbursable we are not able to do what we know is best and what will actually give us the return on that investment in the long term. How would you advise us on how to navigate that tension in the short term when we do not have the resources to invest on the front end in what we know is right?

Rodney Whitlock
Yes (I will stick with the monosyllabic answers as long as I can get away with them)! I totally understand that you are describing a structural problem in the system. You have found the solution to more comprehensively provide coverage and you are dealing with a damnable round peg that will not fit in a square hole. You keep being told, “Well, make it square.” This is a D.C. issue that we have to work through.

Joanne Lynn
would like to add one item to Rodney’s list that would create efficiency. Something we have not considered that every other country seems to do naturally is to provide services for this population geographically. There is no good reason for there to be 60 home care agencies in Washington, D.C., all of which have overlapping territories, and to spend half of our Medicaid dollars in home care on the inefficiency of creating the illusion of competition. It would be much more efficient if a home care nurse was able to walk down the street and see all 12 people who needed to be seen rather than 12 different agencies coming in one at a time. We do not even consider the possibility of delivering services at least somewhat geographically.

Rodney Whitlock
Yes.

Anne Montgomery
Sadly I think we have to bring the panel to a close, but thank you so much and please give a hand to these amazing people.
Katherine Hempstead
I am Kathy Hempstead from The Robert Wood Johnson Foundation. I am a substitute moderator for this panel and I will get out of the way of the presenters as quickly as possible. I came in late this morning, but I did hear Stu Altman make that great comment that if you want to spend less, then spend less. This reminded me of one of my favorite lines from The Good, The Bad, and the Ugly, which was spoken from a bathtub, “When you have to shoot, shoot, don’t talk.”

The presenters on this panel are going to talk about areas where we could spend less and, who might need to take the lead in doing so. We will hear from Darrell Gaskin, Chapin White, Rena Conti, and Charlie Roehrig. I see many of my friends in the audience. If anyone has brilliant ideas about health care cost drivers and new projects, please come see me at the break because I always like to hear new ideas. Without further ado, I will turn things over to our speakers.
LET’S BE REAL ABOUT OUR HEALTH SPENDING PROBLEM

Darrell Gaskin

Thank you, Kathy. I appreciate this opportunity to talk to you about health care and spending. I want to provoke you to think about this issue from a global standpoint. I appreciated Stuart’s comments because they give mine added context.

This is the problem: we are spending over a sixth of our economy (over $3 trillion and approximately 18 percent of GDP) on health care. Of that spending, 20 percent ($646.2 billion) comes from Medicare, 17 percent ($545.1 billion) comes from Medicaid, and 33 percent ($1,072.1 billion) comes from private health insurance (as of 2015). The bottom line—this is too much! Compared to what other countries spend and what we get for it, we are clearly spending too much. Regardless of whether you compare the spending on the government side, the private insurance side, or out-of-pocket, it is simply too much spending. We are like someone who has 100 pairs of shoes in their closet. An observer of this closet would say, “I think you have too many shoes, you should spend less on shoes.” The rest of the world is looking at us and saying, “18 percent is too much!”

Figure 1 shows health care spending as a percentage of GDP for all OECD countries from 1980 to 2013. The U.S. is clearly the outlier in this group of countries. Everyone else is spending between 9 and 11 percent. If we are going to approach that range, we will need to consider radical actions because we are not currently bending the cost curve. We cannot simply slow the pace of growth, we have to figure out a way to take money out of the system and put it in other places.

It turns out that health care is complicated! This is not your average competitive market; we cannot rely on market forces to bid down the cost of health care delivery. Too often we consider the market economy and government as a dichotomy, as though it is either one or the other. The government is not bad. The market is not bad. This is a false choice. We should not be trying to pit them against each other if we are going to ever determine how to spend less than 18 percent of our economy on health care. Anyone that seriously studies markets understands that they cannot work effectively without government. Anyone with a dollar bill in their pocket has already assented to the fact that we need a government to regulate our markets.

Government functions in markets first to establish a store of value so that we do not have to barter. It also sets rules that enforce contracts and allow transactions to take place in a safe environment. Without government, it is a Wild, Wild West where agents have to enforce contracts. Anyone who has participated in an underground economy understands that such a situation necessarily means violence.

**Figure 1.**

Health Care Spending as a Percentage of GDP, 1980 - 2013
I study health care precisely because it is complicated. Each transaction does not involve a single buyer and seller with perfect information. Instead, it involves several agents: consumers who become patients, health care providers across the continuum of care, health plans, and sponsors. My interest in health care markets is motivated by a desire to understand the interaction of these agents and how they produce a transaction where health care is delivered to a patient. Given the complexity of health care markets, there will not be a simple solution to control costs.

Can providers realistically help us solve our spending problem? No! Why? Because their fundamental motivation is to sell. It would be like going to a car salesman and asking him to help you spend less on a car. It is not that they are evil. Similarly, you would never go to your boss and ask for a pay cut instead of a raise. None of us would do that, so why do we expect providers (many of whom are the best and brightest) to take less money to do the same work? We cannot expect to get from 18 percent to 10 percent by asking providers to solve the problem.

Can health plans solve our spending problem? No! Why? It is not in their financial interest either. Health plans are financial intermediaries that typically make their money as a percentage of the transaction. It would be like an agent telling their client, “I am going to sign this new contract for you, but we are going to take less money.” That would never happen. Again, they are not evil people. If the value and volume of the premiums decline, they will make less money.

Can consumers solve the spending problem? No! Why? Consumers as patients are the least informed buyers in the marketplace. They cannot accurately evaluate the service before or after they purchase it—ex ante or ex post the transaction. They do not know when they are paying less if they are getting less. How many of you, when having elective surgery, would leave a center of excellence in order to get the surgery done by someone who said, “I can do it for 50 percent less”? When I got my first job with health insurance and sought to pick a primary care provider, I asked my physician friends, “How do I pick a physician?” The answers they gave me were nonsensical. They told me to interview the physicians and pick someone who you feel comfortable with. What doctor would spend 30 minutes for free with me while I interview them about becoming my doctor? I thought my friends would tell me to check where the physician went to school, or how many patients they had, or where they did their residency. They did not say that, because as patients, how would we know? We also cannot depend on consumers to solve the spending problem because sick people are bad negotiators. When we are sick, we are unwilling to bargain on prices. When someone goes grocery shopping while they are hungry, they end up buying too much. Similarly, when you are sick, and someone tells you they can make you better, you are going to buy more.

Can sponsors solve the spending problem? Perhaps. As long as they honestly convince consumers to let them. We must dispel the myth that sponsors give us health insurance. This is not true. We are actually giving them something. Private health insurance is compensation for work we provide. Medicare is payment under the social contract between workers and the federal government. We pay taxes and Medicare is available when we come of age. Medicaid is payment under the social contract between citizens and residents and government. We pay taxes and the safety net will be available. Most people do not connect their expenditures with the sponsor’s behavior. This is one of the reasons why, when we attempted to reform private health care in the 1990s, the employee groups pushed back and said, “No, you cannot do this. You are taking something away from us.” They thought health insurance was a gift from their employers. We still do not think about employer-provided insurance as compensation.

It is similar to when I took my nephews to McDonald’s. When they knew the money was coming from my pocket, they would ask for the Super Value Meal. If I simply gave them $5, they would buy a single hamburger and ask for a cup of water. They did not perceive the money that was coming out of my pocket as money that was coming out of their pockets.

We have disconnected the taxpayer and employees from the beneficiaries in Medicare, Medicaid, and employer-
The hard truth is that, to solve our spending problem, someone is going to have to take less. In our current system, the people who take less are the poor, the very sick, and their providers. This student sat in my office and told me about all the things they were doing, but was still failing. Eventually, I decided to look at what the other students were doing, because perhaps I was not communicating the material well enough. I discovered that the other 12 students were doing quite well. Finally, I said to the failing student, “I do not know what you are doing to study for this course, but maybe you ought to study with your friends in order to pass the exam.”

While solving the health spending problem is truly complicated, there are solutions. The rest of the world adopted these solutions and they are “passing the test,” while we continue to fail. If we decide to enact national health insurance, or a type of national health system, or global budgeting, or some combination, we could get a better grade. But if we decide to continue tinkering around the edges, as we have been doing for at least the past 20 years, we will soon reach 20 percent of GDP. Spending that much of the economy on health care is particularly bad because there are many valuable items on which we could be spending our money.

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Is all this health care spending good for us? No, no, no! From a societal perspective, health care spending does not create value. At its best, health care spending restores our functional status. However, it also crowds out other spending that creates value. I can argue that:

- Educational funding increases human capital.
- Transportation spending improves the ability to move people and goods.
- Consumer goods/services spending enhances the quality of life.
- Defense spending protects society from war.
- Social services improve our quality of life.
- Public health spending protects health and saves millions of lives at a time.
- Public safety spending protects lives.

I cannot make a strong argument that significant spending on health care delivery adds tremendous value to our society. Health care is the thing you buy but hate to use. How many of us pick up our insurance policy and say, “Wow, a new insurance policy, I cannot wait to use it”?

I will end with a story. I am a university professor and was teaching a course where one of the 13 students was failing.
Chapin White

Hello. I am Chapin White, a health economist with the RAND Corporation. Anything I say today reflects my own views. Thank you Darrell for boiling this issue down to its essence. I am going to stress the theme that cost control is actually not that complicated. The question is not, “can we control health care costs?” but rather, “do we want to?”

The premise of this symposium, from its beginning in 2011, is that of course we want to control health care costs, we simply need to figure out how—to find the right levers, or the right combination of value-based payment reforms. I disagree. We know how to control costs. The question is whether we want to do it. Let me expound on this point by exploring three false premises I see in the health policy space.

**FALSE PREMISE #1:** We want to control Medicare costs, but we do not know how. There is a prevailing notion that price controls do not work to bring down Medicare costs. A 2013 paper by RE Moffit and A Senger contained this summary:

**Price Controls.** Traditional Medicare relies on conventional methods of “cost control”—ratcheting down reimbursements for doctors and hospitals. But these methods do not, in fact, control program costs.

This is completely false. The long-term evolution of Medicare has been to progressively apply price controls in more segments of the system, and they have worked beautifully, exactly as you would expect. The recent trends in Medicare spending are shockingly flat (Figure 1). The Affordable Care Act cranked down the screws on these regulated prices and it is working. Price controls not only produce direct savings on the amount paid for each unit of care, but they eventually begin to restrain volume—a
double bang for the buck. Again, the question is not, “how can we save money in Medicare?” We know how to do it. The question is, “do we want to use the levers we already have?”

**FALSE PREMISE #2:** We want to reduce private health plan costs, but we are at the mercy of consolidated health care systems—we do not know how to block or undo consolidation. Figure 2 shows prices for hospital inpatient services paid by private health plans relative to Medicare rates. The orange line is prices paid by private plans, and the 100 percent line is prices paid by Medicare. Private plans are becoming detached from economic reality, drifting off into the stratosphere. Stuart Altman mentioned this price problem, but I think he significantly understated it.

Figure 3 displays data on hospital outpatient prices paid by private health plans in the State of Indiana. (Thank you to the Robert Wood Johnson Foundation for support of this work.) Each bubble is a hospital, and they are organized by hospital system, ordered from lowest to highest average price for outpatient services. The thick blue line represents Medicare rates. We ran these private claims through Medicare’s groupers and pricing formulas. The higher priced hospitals are four or more times the Medicare rates, even though they are the exact same services provided by the exact same hospital. The prices are unhinged from economic reality.

I am going to dig deeper here and perhaps make some people uncomfortable. Let us look specifically at one of the highest priced hospitals, Parkview Regional Medical Center in Fort Wayne, Indiana (Figure 4). They are getting five times the Medicare rate for their hospital outpatient services. Holy moly! What I love about the street view image of this facility is that there is a crane in the background—yes, they are building a large, new cancer center. While certainly not alone, this facility is emblematic of our broader health care cost problem. Where is this hospital located? It is on the north side of Fort Wayne in a lovely neighborhood. Mike Packnett, the CEO, is a local hero and has been recognized as the business leader of the year in this area. This is a nonprofit hospital, so you can look up the organization’s 990 form. Mr. Packnett is making approximately $1.5 million a year, which might sound like a lot of money, but let me put this in perspective. The Medicare hospital cost report shows that this hospital made $104 million net income in 2015. They are raking in the money with an incredible operating margin! This is the U.S. health care cost problem in a nutshell.
Parkview is a consolidated system and they have a lock on Fort Wayne, Indiana. What can we do about this situation? We know exactly how to handle high negotiated prices paid by private health plans. Bob Murray made the brilliant argument in a 2013 blog: Limiting the payments for out-of-network care provided to the privately insured will reduce in-network negotiated prices.

Can this be true? Absolutely! Figure 5 comes from a paper published this month by Erin Trish et al. It compares prices paid by a Medicare Advantage plan and commercial plans relative to Medicare fee-for-service rates. Medicare Advantage involves private health plans negotiating prices with providers, but prices for out-of-network care is strictly limited to the Medicare fee-for-service rates. The prices are compared across the same services, same providers, and same insurers. The negotiated prices for the Medicare Advantage plan are in line with the Medicare fee-for-service rates. The negotiated prices through the commercial plans, where the only difference is that there is no limit on out-of-network prices, range much higher than Medicare fee-for-service rates. The difference in negotiated prices is smaller for primary care services, because it is a more competitive market. But when you move away from primary care, the difference becomes larger, up to twice as much as Medicare fee-for-service rates.

Similarly, Bob Berenson and colleagues studied the Medicare Advantage market concluding that negotiated prices in Medicare Advantage are pegged to Medicare fee-for-service rates because of the limits on out-of-network prices. This evidence clearly rejects the notion that we do not know how to control prices or costs in private health plans.

**FALSE PREMISE #3:** Efforts to repeal and replace the Affordable Care Act are about bringing down health insurance premiums. If repeal and replace was seriously dedicated to lowering premiums, it would commit to providing cost sharing reductions, strengthen the individual mandate, increase the standardization of health plans, and add a public option (Medicare buy-in). Repeal and replace does not do any of these things and often does the opposite.

All of which leaves us with the foundational ethical question we must face: What do we want from our health care system? Figure 6 is a slide from Uwe Reinhardt’s presentation at last year’s symposium, and nicely articulates the divide in our nation’s health care system. Some view health care as a pure social good that ought to be equally available to all and be financed by ability to pay. The competing view is that health care is a private consumption good whose financing should be primarily an individual responsibility. This is the disagreement that is playing out in Congress. Even though this is not how we usually set up the debate, this disagreement flows into most of the arguments concerning cost control.

Our willingness to control health care costs is tied to our vision for an ethical health care system. What do we want? There is no obvious correct response to the way Reinhardt has framed the issue. Progressives are shocked that anyone would disagree with their vision that controlling health care costs is an obvious goal and the only question is how to accomplish it. It is important to acknowledge that, on the more free market side, many proposals that aim to deregulate markets will drive up costs and increase revenues to health care delivery businesses.

I hope I have provoked you today. I am interested to hear the other presenters and reactions.
DRUG SPENDING AND HIGH PRICES: UNDERSTANDING THE PROBLEM & POSSIBLE SOLUTIONS

Rena Conti

Thank you for the opportunity to speak today. I will address yet more controversy with drug spending and pricing.*

The challenge of drug spending can be summed up in one phrase: “it’s the prices, stupid.” Drug spending is a small percentage of medical spending but has grown substantially over time. Approximately 16 percent of medical spending is on drugs. This is double what it was a decade ago, and is projected to approximately double in the next decade.

Is higher spending a good thing? Spending levels and trends have two components (as is true for all of health care): utilization and price. Use has grown significantly largely due to the aging of the population and innovation. Frankly, this innovation has helped provide safe and efficacious treatments for many chronic illnesses. There is, however, waste in this use. My colleagues and I have estimated that wasteful utilization, even on the most expensive drugs where physicians face financial incentives to use these treatments, is approximately 10 to 15 percent of overall use. This is consistent with what we see for waste in other types of medical inputs.

The more serious problem concerns the pricing for existing and breakthrough therapies. The prices for many new drugs range from $50,000 to $300,000 per person per treatment year. This is much higher than the prices for new drugs two decades ago. The advent of $500,000 treatments for a cure embodied in a pill is coming. It may be next year, or the year after that, but this is going to occur.

To illustrate why people are so frustrated with drug pricing, consider this: The prices of drugs for the treatment of cancer can easily amount to a year of college at an august private institution like mine, the University of Chicago. It is one to five times the median household income in the U.S., which was $59,000 in 2016. It is 1 to 8 times the median household income of seniors who are living on fixed incomes. The median senior is living on a bit less than $39,000 a year (in 2016). Wage stagnation and income inequality are serious problems in the U.S., and high drug prices compound those anxiety-inducing forces.

Furthermore, high and increasing prices do not reflect a corresponding increase in value. While there is a positive correlation—better drugs do command higher prices—drugs introduced today with higher prices do not indicate that the quality is better than a decade ago. In 2014, David Howard and I published a paper suggesting that the greatest predictor of the prices of cancer drugs launched today were the prices of drugs launched in the previous year. In other words, they are reference pricing off whatever the ambient willingness to pay is for these therapies.

In fact, patient cost sharing is higher today than it was in 1995. And, due to changes in benefit design after the Affordable Care Act, more Americans are facing deductibles and copayments that reflect the list price of these drugs. I sit on a government relations committee for a provider
position this puts states in who must choose between paying for roads and schools versus hepatitis C treatments—which provide excellent value, but do so far into the future.

GREED

The U.S. drug system is complex and opaque. There are three prices for each drug: the list or sticker price (similar to cars, no one pays the sticker price unless they are uninsured); the acquisition price that pharmacies, physicians, and hospitals pay (which includes a series of discounts and rebates such as 340B discounts and bulk purchase rebates); and the reimbursement price. Contrary to popular opinion, the patient’s payment is attached to what the insurer decides the patients are going to pay, not what the manufacturer charges. The complexity and opacity of the different parts of this system serve their masters, and exacerbate the pricing and access problem. As I explain to my family in Brooklyn, everyone is “on the take.”

The ranks of entities that profit from the current pricing system includes familiar players you have heard blamed for the problem in the past: pharmacy companies, their shareholders, and the attorneys that help branded companies charge high prices and forestall generic competition. Yet, even generic drug manufacturers charge high prices for long-since available drugs, and actively participate in “pay-for-delay” deals. Innovators are not the only greedy ones in the market; generic manufacturers are also now engaged in setting ridiculously high prices.

Recently, parties who act as middlemen have been revealed as profiting from discounts and rebates. These include pharmacies, PBMs, and insurers. The dirty secret, hidden in plain view, is that physicians and hospitals are now also making money off this system. We have long appreciated

Contrary to popular opinion, the patient’s payment is attached to what the insurer decides the patients are going to pay, not what the manufacturer charges.
that they face incentives to not necessarily use the least expensive therapy. The increasingly obvious truth is, however, that reimbursement for physicians and hospitals is often pushed towards using new therapies where they profit off the sticker price and the discounts and rebates that are available to them. For example, the average 340B hospital makes between $10 to $100 million a year on the uses of these drugs.

What can we do? I believe the public outcry reflects a simple truth: we care about access to these drugs because they improve people’s health, they are relatively cheap compared to other inputs in the system, and they may have important spillovers onto others’ health and wealth. Yet, our current system fails to deliver adequate access. Interested parties all claim that high prices reward innovation—which may be true on the margin—but it is deployed with a passion to hide that everybody is “on the take.” Everyone makes money from the high prices of drugs except middle-class patients and taxpayers.

I am not a cynic. I believe that we can right the ship, but the solutions require us to get serious. There are no magic bullets in a system that is this complex and for which the perversity has infiltrated all parts of our medical industrial complex. When you hear simple solutions such as, “it’s big pharmaceuticals’ problem, they can simply lower list prices,” or “the problem is direct to consumer advertising—we will solve the problem by banning ads,” practice rolling your eyes like your best teenage self!

I believe the best reforms embody three principles:

- Focus on lowering the financial and nonfinancial cost to patients and their families to access drugs when they are clearly safe and effective. This can partially be done voluntarily by insurers who could alter benefit designs to encourage the use of therapies that we know are effective and are likely to have spillover savings and benefits throughout the system. This will likely also require legislation built into the public programs.

- Reduce the greed that pervades our system, particularly among the middlemen who do not promote value. They make money off the system, but do not add efficiency or contribute to higher quality health care delivery. This is the hardest but most important of the three principles.

- Editor’s note: Professor Conti did not reference her slide deck in this presentation, but they are available on the symposium web site.

- Continue to ensure the financing of true innovation—the breakthroughs that will transform lives, reduce morbidity and mortality, and have implications for communicable disease and the health of others. We need to think outside the box to address the other market failure where the bill comes due today but the benefits come out in the future. There are many emerging solutions to this challenge worth trying.
THE HEALTH SPENDING SLOWDOWN OF 2008-2013: IMPLICATIONS FOR SUSTAINABILITY

Charles Roehrig

I am Charlie Roehrig with the Altarum Center for Sustainable Health Spending and, as such, would like to add my welcome to everyone. I would also like to congratulate Paul Hughes-Cromwick who masterminded yet another outstanding symposium, and thank Kathy Hempstead and the Robert Wood Johnson Foundation for their continuing support.

The growth in real per capita health spending depends upon changes in the prevalence of disease in the population and changes in the cost of disease treatment.

This has been a terrific panel thus far. I am debating whether to cede my time to Darrell so he can talk some more, or perhaps give my talk, but I am not that altruistic, as has been pointed out!

The Centers for Medicare and Medicaid Services, in their annual national health expenditure reports, proclaimed that record low rates of health spending growth began around 2009. I will discuss this historic slowdown in health spending that persisted through 2013, analyze its sources, and address future implications. Expanded coverage pushed the rate of spending up for a few years but, with the leveling-off of insurance take-up, we now seem to be gliding back down. Will we return to the record low spending rates and what if we do—will it signify that we are now on a sustainable path?

Let us begin by looking at the era before the slowdown and focus on real per capita health spending to correct for economy-wide inflation and population growth. Between 1996 and 2005 the real per capita growth rate was 4 percent (Figure 1). That sounds low, but remember, I have taken out 2 percent-plus inflation and a percent of population growth. It is actually high. During that same timeframe, real GDP per capita grew about 2 percent. Thus, health spending was growing 2 percent faster than GDP – well above what would be sustainable long term as I will discuss later.

The growth in real per capita health spending depends upon changes in the prevalence of disease in the population and changes in the cost of disease treatment. We estimated that three-quarters of the 4 percent growth between 1996 and 2005 was due to the rate of increase in the cost of treating a person with a specific disease, and one-quarter (roughly 1 percent), was due to increased disease prevalence, or treated prevalence to use a Ken Thorpe phrase. In this particular era there was a 3 percent per year increase over and above inflation on what it cost to treat a person with a disease. David Rousseau and I had a Health Affairs paper in

FIGURE 1.
2011 showing this result and argued that to control the high rate of health spending we better address cost per case. What happened? In the next nine-year period, the real per capita growth rate was cut in half, all by addressing real cost per case (Figure 2).

We effectively hit the big ticket item! What happens when we zero in on the period of historically low growth (Figure 3)? To the right of the dotted line is the 2008 to 2013 experience. Over that five-year period, the cost of treating a diseased person—holding the level of illness constant as best we can—barely increased! We still had 1.8 percent overall growth largely because of the increased treated prevalence. How in the world did we manage to hold the cost of treatment to the rate of inflation? I was certainly surprised by this finding.

To better understand this I investigated price behavior (Figure 4). On the left-hand side, the first bar shows the growth in cost per case during the high spending growth period. The second bar shows health care price growth relative to inflation during that same period. Health care prices include those for physician services, prescription drugs, hospital services, and other goods and services. Why would the cost of treating a disease grow faster than the underlying prices of the goods and services consumed? Just as Darrell did so well, I will give you an analogy. If the price of groceries stayed fixed you could still increase costs for a meal. You could buy more expensive groceries, or make a larger meal. If someone else was paying, you might do that. Unfortunately, perhaps half of it would be thrown away as happens at these fancy restaurants that many of us frequent. That is what happened here (not the waste part which is a topic for another talk!): the cost of treating a disease went up much faster than the prices of the inputs because we were delivering more care to patients for the same disease.

Look at the far right bars describing the slowdown period. Prices were still rising at essentially the same rate as they were during the high spending period, but we held spending per disease level with inflation. We actually cut back on treatment intensity. I leave an explanation of how that happened to others. I will only note that this time period aligns exactly with the Great Recession and its aftermath, and econometric studies have shown that recessions tend to push down the growth rate in health spending incrementally for about five years. Perhaps it was the recession that helped reduce treatment intensity.
Let’s be optimistic and assume that we can hold cost per case to zero growth without needing a recession to do it. Will this hold overall health spending growth to a sustainable level?

When the Affordable Care Act (ACA) passed we, in the Center for Sustainable Health Spending, set out to define what rate of increase in health spending would be sustainable (historical growth rates had regularly been declared “unsustainable” but without addressing what would be sustainable). What would that rate be?

The ACA came with the philosophy that the federal government would make adequate health insurance affordable to everyone via expanded Medicaid, targeted subsidies for private health insurance in the individual market, and a strengthened Medicare program. We thought that any growth rate in health spending that did not compromise the government’s ability to live up to this promise would be sustainable. That perspective led us to review the terrific Congressional Budget Office (CBO) projections of the federal budget, annual deficits, and the attendant debt-to-GDP ratio over time. What rate of growth in health spending causes this ratio to run out of control? That is our approach, but to keep it simple for now, think of the State of Massachusetts aiming to keep health spending at roughly the rate of growth as state income (state GDP). With health spending growing at GDP plus zero, maybe you have a puncher’s chance of sustainability, although there are still difficulties for balancing the budget into the future (see our triangle of painful choices for more details).

In the high spending era, real per capita GDP was growing by 2 percent per year and that would provide a target for health spending growth to realize a GDP plus zero scenario. With expanded coverage leveling off, we could perhaps achieve the slow growth experienced during 2008 to 2013—roughly 1.7 percent growth in real per capita health spending. Does that imply an outcome near GDP + 0? Unfortunately not, because the new long-term CBO projections are estimating that real GDP per capita will grow at about 1 percent, a percentage point lower than the 2 percent growth from the earlier period. This translates into GDP plus 0.7 percent health spending growth and is almost certainly unsustainable. In summary, even holding the cost of treating a disease to the rate of inflation does not get us to GDP plus zero. This is because of the growth in treated prevalence.

Let us take a closer look at treated prevalence. The data I have presented thus far concerns the prevalence of individual diseases. A different approach, looking at prevalence by numbers of chronic conditions, interestingly gives the same basic result. Using 2008 data, 40 percent of the population had zero chronic conditions, 24 percent had one, and so forth (Figure 5). But, 24 percent of the population had three or more. There are higher costs to treat people with more conditions, and this group accounts for 62 percent of spending.

What happened between 2008 and 2013? For each category of three chronic conditions or more, the corresponding percent of the population falling into that category went up, while it fell for zero, one and two conditions (Figure 6). When the population shifts into higher

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**FIGURE 5.**

Prevalence by Numbers of Chronic Conditions

The share of the population by number of treated conditions: 2008

In 2008, 24% of the population was treated for 3 or more chronic conditions and accounted for 62% of health spending.

**FIGURE 6.**

A Shift Toward Greater Multiples of Chronic Conditions

The prevalence of 3 or more chronic conditions increased: 2008-2013
numbers of conditions, spending rises. By this approach I also find the 1.7 percent effect, whether looking at individual disease prevalence or shifting into the multiples.

What are these condition combinations? Hypertension, hyperlipidemia, and arthritis were present in over half of the population with three or more conditions (Figure 7). The red bar shows the change in prevalence from 2008 to 2013. The fastest growing conditions were Lupus, mental disorders, back problems, and arthritis. (It would be interesting to determine where the opioid epidemic fits into this.) A significant finding, not shown here, is that diabetes, hypertension and hyperlipidemia appear as a frequent triple occurrence.

Some of the shift into greater numbers of chronic conditions is due to aging. CMS estimates that aging has added about 0.6% to spending growth in recent years, so perhaps one-third of recent shifting is due to aging. As Jessica quipped, there is no policy to take on aging, but there certainly are things we can do to slow the shift into these multiple chronic conditions. For example, the prominent combination of diabetes, hypertension, and hyperlipidemia has strong links to obesity and suggests the importance of dealing with this societal problem. More effective interventions into the social determinants of health could be key to slowing the shift. But given the aging of the population, we will clearly continue to see shifts into these higher multiples of chronic conditions. As George Clooney said in O Brother, Where Art Thou? “Damn! We’re in a tight spot!”

To sum up, the main source of excess health spending growth between 1996 and 2005 was cost per case which contributed 3.1 percentage points to spending growth. This factor was almost completely controlled during the 2008-2013 slowdown but real per capita spending still grew by 1.8% per year due to increases in treated prevalence, characterized by shifts into greater numbers of chronic conditions. The slowdown has been substantial but growth remains at unsustainable rates. Even if we can control treatment costs per unit of illness to the rate of inflation, spending will grow at GDP + 0.7 unless the shift into greater chronic condition multiples can be slowed. The aging population will make this more difficult.

For the last three or four years, health care prices have tracked economy-wide inflation (the GDP deflator). Almost certainly that is because Medicare and Medicaid have kept their prices extremely low, and while private price growth is higher, the net result is stability with general inflation. If we could successfully eliminate wasteful spending, the cost of treating disease could grow more slowly than the rate of inflation. If we go radical, as Darrell noted, and adopt the approaches of other industrialized countries, we could achieve much lower health care prices, and potentially drive the cost of treating disease down further. But these things will not occur until we are sufficiently desperate.

My analogy is the UAW and the U.S. auto companies. UAW representatives were never going to make sustainable concessions because they did not believe that the auto executives were negotiating in good faith. Each time they gave in, they would see the companies making large profits. However, as the Great Recession strengthened, it became abundantly clear that the auto companies really did not have sufficient reserves, as two of the “Big 3” went bankrupt and the 3rd nearly did so. At that point, deals were made that most analysts thought could never happen.

With health care spending, will we get to that point or will we do something before then? I do not know. With that, have a nice day!
Katherine Hempstead
To give you the skinny: Darrell set the table for us by talking about where we should not look for help and suggested that we take lessons from the smarter countries around the world; Chapin pointed out that we are paying too much to providers and made suggestions about how to improve that; Rena discussed how we are paying too much on drugs and made suggestions about how we could do better; and Charlie notes that we are too sick, we have too many conditions, and we spend a lot of money on them even if prices are not rising. Let us squeeze in a few questions.

Audience Participant
I would like to provide a comment, and unfortunately I probably will not be the most constructive. I am a medical doctor, what do I know about health care?! I think that the spending in the United States should be done differently—we should spend better, not less. On the issue of whether this is a social privilege or right, I would say the answer is both and that it falls on a spectrum. There is a difference between testing a newborn baby for an inborn error of metabolism, which is clearly a social good, and physical therapy for a person who sprained their shoulder playing golf on Sunday. That is more clearly a private interest. If we look at the spectrum and address these differently we could find good solutions. Finally, I believe there are magic bullets. There are new ideas but these are viewed through each individual’s ideological perspective. If it conflicts with your view, you will not look any further. Thank you.

David Nexon
This question touches on the first panel and the CBO projections. We tend to look at health care spending in isolation. Now we are broadening to say that social investments and social determinants of health are part of the health care spending perspective. But we do not hear much about the effects on GDP. The Milken Foundation and others have shown that if you improve health, both through medical treatment or reductions in chronic diseases, you get a significant increase in GDP because of increased productivity, reduced disability, and increased labor force participation. Should that be a more prominent feature of the way we assess health care costs and consider how to shape the system of the future?

Charles Roehrig
I think this relates to Darrell’s discussion on how much health care is worth. We have done work on the social determinants of health, including education, and the effects on productivity. Consider the federal budget problems that CBO describes, and the Altarum triangle of painful choices (our analysis of sustainability), and it is clear that health care spending is crowding out spending on social determinants. The spending categories that are declining all concern safety net programs plus national defense, of which the latter is
Mike Miller

Rena mentioned “me-too drugs.” I have been working in the bio pharma world around innovation, competition, market forces, and the R&D process for a long time. Interestingly, in the 1990s people were screaming, “You are not innovating, you are just developing me-too drugs,” and now we hear, “You are not delivering enough me-too drugs because that is what we need for competition to bring down prices.” Can you discuss how to foster more competition among insurance companies, delivery systems, and providers; whether it can be done at the state level with more use of antitrust or other kinds of activities; and whether that is a route we can take instead of single payer or government price controls or regulations?

Rena Conti

To clarify, I was not making the argument that we need more me-too drugs.

Darrell Gaskin

First, I applaud the movement to ask health care delivery systems to consider the social determinants of health and to try to address them for the patients that they serve. But this is a second best solution for me because why should I ask hospital administrators and doctors to improve the school system? We should put the money in the school system and improve it directly so trained educators have the resources to do their jobs. Second, I want to again get you in this room to accept the unthinkable, that 18 percent of GDP is too much! Somehow, we have to deliver the outcome that the rest of the developed world has. If governors could determine a way to control their Medicaid budgets, they could spend that money on other areas that could improve their states. They cannot do it by themselves because the Medicaid budget is tied to the entire health care system. Unless we decide to not spend over a sixth of our economy on health care delivery, we are going to be stymied asking physicians to do what we should ask housing officials, or transportation officials, or education officials to do. The sad inefficiency about this is that physicians and administrators are the most expensive labor in our society; we will not save money with this approach.

If you spend more on health, you are going to spend less on social determinants. Paradoxically, you might have a worse effect on productivity (and health!) by spending more on health and less on the social determinants.

Rena Conti

Yes, we should have innovation focused on improving health that has spillovers into people’s ability to work, but that proposition is radical because it means that we spend less on innovation related to Alzheimer’s treatment and cures, and more on innovation that affects young people, such as mental health and substance abuse. I am all for that proposition, but it means we would have to radically change our orientation of the types of innovations we fund, both publicly and privately.

Charles Roehrig

I suggest publishing every price that is charged for every item and make it easy to find. Do not bury the rebates; do not bury any information.

Chapin White

Antitrust activity provides hope but it is a false hope. If you are in a health plan, it must offer you heart transplant services, level-one trauma care, access to a burn unit, etcetera. To operate those specialized services at a minimally efficient scale, even a large urban area can only support either zero or one of those. To the extent that such specialized procedures must be part of the basket of services, and due to natural vertical integration where
patients are fed up to these high tech providers so that they can inevitably lock down a geographical area, antitrust law will have limited scope. You may be able to challenge hospital purchasing of physician organizations, or hospital-to-hospital mergers, but you cannot change the returns to scale that exist both on the provider and health plan sides, in the health care delivery system. I believe the way to get out of this flood of consolidation and its price impacts, is by adopting Medicare’s fee-for-service approach—to have a consolidated buyer who does not care how consolidated the providers are.

**Rena Conti**

I agree with Chapin. My colleagues are presenting our work today at the FDA. We show that the vast majority of generic drugs that have experienced significant price increases are manufactured by monopolies. Those drugs have revenues that are actually quite low annually and would never trigger an antitrust scrutiny. Antitrust may help, but it is not going to be the silver bullet. We have monopolies or duopolies in most health care markets, including drugs, hospital systems, and physician groups who have grown substantially over time, and have locked-down specific markets. The antidote to monopoly on the sell side is monopoly on the buy side. If we want to address the pricing or the re-adjudication of spending then we need to get tougher on what we are willing to pay for these treatments. We may be moving towards administered prices, or a system of inputs that are paid fee-for-service with administrative add-ons for doing the right thing related to quality or helping the particularly vulnerable.
This is obviously an extremely timely panel! Typically, I am well prepared to moderate, as I usually sit through the entire morning and wrap up at the end of the meeting. Today, you will be amazed that I hurdled through that door five minutes ago, so I will have to be more improvisational than usual. Anything we agree on during this panel may change by the time we leave in an hour. The situation is that much in flux! As we enter this panel, the Senate vote is still on. An hour from now we may find out something very different.

Our panelists are Gail Wilensky, an economist and senior fellow at Project Hope, John Ayanian, the Director of the Institute of Healthcare Policy and Innovation at the University of Michigan, Jean Lambrew, senior fellow at the Century Foundation and formerly in the Obama Administration White House Office of Health Reform, and James Capretta, resident fellow and the Milton Friedman chair at the American Enterprise Institute. We will start with brief presentations and then transition into a more freewheeling discussion.
Beyond the ACA: Health Policy and Sustainable Health Spending

SIZING-UP HEALTH CARE REFORM OPTIONS & PROSPECTS

Gail Wilensky

To put it mildly, we are in an interesting period for health care policy. I assume everyone knows that with two more Republicans declaring they will not support the Senate bill, its passage is doomed. This means, as I have been trying to remind people all year, that the Affordable Care Act (ACA) remains the law of the land—until it is not. At the moment, it is not clear whether there is sufficient agreement between Republicans and Democrats, or within Republicans across the conservative and moderate camps, to pass legislation.

Many people may regard this as a great win. It is not the worst outcome I can imagine, because the ACA managed to get 20 million more people insured. But there are serious problems that remain with the ACA, not all of which can be reasonably attributed to Republicans, such as the lack of stability and the amount of churn occurring with the exchanges in 2016. However, since the exchanges represent a minority source of the newly insured, what happens to Medicaid is much more important.

In my opinion, Medicaid is an area that needs serious reconsideration. It was always unlikely that a 90 percent match rate for the expanded population would be a successful long-term strategy. Among other things, it makes very little sense to have the least poor of the Medicaid population getting the highest match rate from the federal government. Having different match rates for different programs under Medicaid simply does not make sense. I understand that it was a “walking-in” strategy, but at some point we need to determine a compromise between the old and the expanded rate that makes sense. Given the challenges states face in their never-ending ways to be fiscally creative, we need to have a discussion about whether there is a way to structure matching grants—supposedly what underlies cost containment now and in the future—when the federal government is not paying 100 or 95 percent of the cost as it does for the expansion population.

From the many interesting ideas and plans being proposed, I am a big fan of the Cassidy-Collins legislation, despite it not getting any serious consideration. Under that legislation, if a state likes the ACA, it can keep it while absorbing a 5 percent cut to the subsidies. Conversely, a state can take 95 percent of the federal funding and set up a direct deposit, refundable tax credit system with paired health saving accounts (HSAs). I suspect the two senators would be willing to consider other options besides the two main options described in their plan. I wonder whether the demise of the current Republican efforts will change the dynamics such that Cassidy-Collins begins to be taken more seriously. In my mind, the biggest question is who will provide the leadership for a more moderate or bipartisan bill? The answer to that has escaped me for at least the last six months, so if people have ideas on this topic, please share them!

* Editor’s note: Readers may be interested in this blog by Gail Wilensky, “Republicans Will Own Whatever Happens to the ACA and Health Care Reform” that was published in JAMA Forum on September 19, 2017.
Beyond the ACA: Health Policy and Sustainable Health Spending

John Ayanian

I am John Ayanian, Director of the Institute for Healthcare Policy and Innovation at the University of Michigan. I have enjoyed learning from the range of speakers today, and I want to thank Paul Hughes-Cromwick and Ani Turner—my Ann Arbor neighbors—for inviting me to speak at the conference. As the only physician among today’s speakers I want to consider not only the consequences of spending but also the health that we are trying to achieve, because medical care matters. As Stuart Altman noted earlier today, if we want to spend less, we need to spend less, but coverage and access still matter because when medical care is provided wisely it makes a big difference for people’s health.

As I review the state perspective and the work we are doing in Michigan to evaluate the impact of the Affordable Care Act (ACA) and the Medicaid expansion, I would like to underscore what we are talking about in terms of health equity and improving health outcomes. I often turn to the story of a man named Jim Waterhouse. In his early 60’s he lost his job and his employer-sponsored coverage, and he became uninsured for several years. He had multiple chronic conditions (diabetes, hypertension, heart disease, sleep apnea) that had been under good control, including some of the same chronic conditions discussed by Charlie Roehrig in the last session. He reduced his primary care physician and specialist visits, reduced his glucose monitoring, ignored worsening dyspnea, discontinued his CPAP treatment for sleep apnea, and deferred a recommended colonoscopy for his new anemia, all of which led to a very expensive $46,000 admission that was very likely avoidable with good primary care.

When he was interviewed after that experience, he noted that he tried to delay care until he became eligible for Medicare, which obviously complicated his condition. This is only one person’s story but it is representative of the situation in the United States before the ACA was passed in 2010. Before the ACA was enacted, colleagues and I did a study of adults in their 50’s and early 60’s who were part of a nationally representative cohort in the University of Michigan’s Health and Retirement Study. We found that if you were a middle-aged adult without high blood pressure, diabetes, or heart disease, shown on the right-hand side of Figure 1, you had a relatively low mortality rate over the next eight years, and mortality did not differ substantially between those with and without insurance. But when you have one or more of these three conditions—and as Charlie Roehrig noted, they often track together—there is a higher mortality risk that is particularly increased for those without insurance.

Adults who do not have access to primary care services to manage their high blood pressure and diabetes are more susceptible to heart attacks, strokes, and kidney failure. These are the health outcomes of real human lives, which is why it is very important when we consider how to control health care costs that we make sure that promoting equity is

FIGURE 1.
Beyond the ACA: and for some people afterwards—is a diagnosis of social exclusion that we should keep in mind.

Public Health led by Ben Sommers investigated mortality in Massachusetts compared to matched demographic counties across the country and how that changed before and after coverage expansion. They found a 2.4 percent reduction in all-cause mortality for non-elderly adults, and an even greater reduction (4.5 percent) for patients with health care-amenable conditions such as diabetes, cardiovascular disease, and hypertension. Interestingly, there was no change in the mortality trend for elderly adults in Massachusetts, suggesting that there was a concentrated benefit among the non-elderly adults who gained coverage.

Massachusetts reform occurred in 2006. In March 2010, we witnessed the signing ceremony for the Affordable Care Act with President Obama and the House and Senate Democratic leadership celebrating this major coverage expansion at the federal level (Figure 3). But the political cartoon released that week in the Washington Post was a vivid harbinger of the intense political strife over the ACA that we have witnessed for the past seven years, and why the ACA has not had an effective co-parenting arrangement between Democrats and Republicans (Figure 4).

Prior to the ACA we had the Massachusetts state health reform. I was a practicing physician in Boston at the time. Colleagues and I studied what happened in that natural experiment where coverage was expanded in a similar way to what the ACA did for the nation. We used quasi-experimental methods (difference-in-differences) to compare Massachusetts with the five other New England states. We found that:

- Massachusetts residents had a marked decrease in cost as a barrier to care;
- (for example, colonoscopies, Pap smears, and cholesterol tests), especially if they were at the lower end of the income spectrum (less than 300% of poverty); and
- Four years after coverage was expanded in 2006, we began to observe health status improve relative to the other New England states—important evidence of why coverage matters.

Shortly thereafter, colleagues at the Harvard School of Public Health led by Ben Sommers investigated mortality in Massachusetts compared to matched demographic counties across the country and how that changed before and after coverage expansion. They found a 2.4 percent reduction in all-cause mortality for non-elderly adults, and an even greater reduction (4.5 percent) for patients with health care-amenable conditions such as diabetes, cardiovascular disease, and hypertension. Interestingly, there was no change in the mortality trend for elderly adults in Massachusetts, suggesting that there was a concentrated benefit among the non-elderly adults who gained coverage.

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FIGURE 2.

Being uninsured before the ACA—and for some people afterwards—is a diagnosis of social exclusion that we should keep in mind.

FIGURE 3.
In 2012, the Supreme Court ruled that Medicaid expansion was not mandatory; it was left to each state to decide whether to expand. Unlike the purely Democratic support when the ACA was enacted, we saw a different approach in Michigan where we had a Republican governor, Republican and Democratic legislative leaders, health care providers, and business leaders agree on Medicaid expansion from a bipartisan perspective, but with certain market-oriented aspects that Republican legislators insisted on including (Figure 5). I would highlight that U.S. Representative John Dingell from southeastern Michigan is the one constant between the two signing ceremonies for the ACA and Michigan’s Medicaid expansion, known as the Healthy Michigan Plan.

Michigan was one of the few states with a Republican governor that opted to expand Medicaid, but with market-oriented reforms such as cost sharing that includes premium contributions for those above the poverty level, copayments for those above and below the poverty level, and financial incentives to reduce this cost sharing—for those who arranged to see a primary care physician, completed a health risk assessment, and worked to address chronic risk factors such as obesity and smoking that influence their long-term health outcomes (Figure 6). This was promoted as a Michigan program to benefit Michigan residents. We have seen about 650,000 low-income adults (for single adults living alone, they qualify with annual incomes of about $16,400) gain coverage. In 2016, roughly $3.5 billion of increased federal funding flowed into the state to pay for the expansion. Hospitals have seen substantial reductions in uncompensated care. This was a model for bipartisan compromise that I would hope other states and the federal government could emulate.

As part of a Section 1115 waiver evaluation, our team at the University of Michigan has been studying the experiences of individuals covered by the Medicaid expansion (Figure 7). About 40 to 50 percent of new enrollees report that their physical, mental, or dental health has improved within the first year of enrollment. Among those who are not working (about a quarter of the new enrollees), 55 percent say that they are better able to look for work, which speaks to the question we were discussing earlier related to employment spillover effects from covering low-income adults before they turn 65. Among those working (about half of the expansion population), nearly 70 percent said that they were
either able to do a better job in their current position or to improve their employment status because of their new coverage. And I would reiterate, these are real impacts on the lives of enrollees!

Hospitals had a reduction in their uninsured discharges and a reciprocal increase in Medicaid-related discharges, but no change in overall discharges over the first two years of the program (Figure 8). The graph shows that across 130 hospitals in the state, in approximately 120 of those there was a decrease in uninsured discharges, which translated into reductions in uncompensated care. From fiscal year 2013 to 2015, uncompensated care fell from 5.2 percent of hospital costs to 2.9 percent. For an average hospital, annual uncompensated care expenses fell from $7.2 million to $3.8 million—a savings of over $3 million. But, for our large safety net providers, such as a Detroit hospital with a high uninsured population before the ACA, uncompensated care fell more substantially from $35.8 million to $19.5 million.

Medicaid expansion has translated into meaningful economic benefits which makes repeal and replacing the ACA particularly challenging. We did an economic modeling study and found that this increase of about $3.5 billion in federal funding coming into Michigan improved employment by nearly 40,000 jobs in 2016, and is projected to support approximately 30,000 jobs through 2021 (Figure 9). This occurs because of added health care spending plus the multiplier effect as this new spending works its way through the economy, along with a decrease in out-of-pocket costs for people who were previously uninsured. State spending (for example, on mental health services or correctional health) falls because these services are now covered under the Medicaid expansion, allowing the state to spend those dollars on education or transportation. Personal income associated with new employment rises between $2.2 and $2.4 billion annually. Moreover, additional economic activity related to this higher personal income is projected to generate about $150 million annually in new state tax revenue, enough to cover the state’s share of the Medicaid expansion costs in 2017. (Here we took a Michigan perspective understanding that if all 50 states expanded Medicaid these economic forecasts would play out much differently.)

Analyses by the Urban Institute, released earlier this month, show the economic effects of the initial version of the Senate’s Better Care Reconciliation Act (Figure 10). The darker-colored states would have substantial reductions,
on the order of 40 to 50 percent, in their relative federal spending levels. States in the South and the Plains regions that did not expand Medicaid would see smaller reductions of about 20 percent. This relates to the concerns we heard from many of the governors on whether this bill should go forward. Even states such as Florida that did not expand Medicaid but experienced substantial expansion of the marketplace would see a reduction on the order of 34 percent in their federal health spending.

These expenditure reductions correspond to increases that would be seen in uninsured rates in non-expansion states, ranging from 20 to 40 percent (Figure 11). However, in expansion states, particularly those with lower incomes such as Arkansas, Kentucky, and West Virginia, there would be a much larger two to threefold increase in the uninsured population under the Senate bill.

The challenge as we consider repealing, replacing or reconstituting the ACA, is that there are many real-life people who are benefitting in terms of their access to care, their out-of-pocket costs and their health outcomes as they access appropriate care. That is where we should focus. How do we preserve the benefits while we try to correct the concerns that politicians across the spectrum have about how the ACA is functioning (Figure 12)?
Jeanne Lambrew

Thank you John. While you may be the only physician speaking today, I am the only former Obama Administration official. Which means, given the title of this session, Beyond the Affordable Care Act (ACA), I will be providing context for its implementation and its prospects.

There is no such thing as a perfect bill. Medicare was created without cost containment. It took until the 1980s before Congress acted to rein in high Medicare costs. Medicaid also hit its rough patches. States found ways to game the system, and Dr. Wilensky actually helped to solve those problems. It took a lot of political courage over many years to clamp down on such abuses. When the Children’s Health Insurance Program was passed in 1997, I believe there were four consecutive years of technical corrections. Even the Medicare Advantage program, which is often lauded as a paragon for how legislation should work, had to be overhauled after rough early years when it was called Medicare+Choice.

Seven years past ACA passage, and only three full years into parts of the implementation, I think the results have been pretty darn good. When President Obama left office, we had the lowest uninsured rate in history. As Gail mentioned, 20 million more people have gained coverage. The Medicare Trust Fund was once projected to be insolvent this year. It is now projected to be insolvent in 2028. While we can debate attribution, Medicare and Medicaid per capita cost growth were negative in real terms between 2010 and 2015. And we have seen improvements in quality in challenging areas such as readmissions and health care-acquired infections.

To repeat—as my former boss was the first to say it—no bill is perfect. We always strove to make the law better. A little-known fact is that President Obama signed into law at least 20 changes to the ACA. These changes were obviously bipartisan, otherwise they would not have passed.

We should begin this discussion with a reminder that the data do not show that Obamacare is imploding (to use the oft-heard cliché in this debate). While premiums were high entering 2017, the premium tax credit insulated many people. In fact, for 85 percent of those who received premium tax credits, the out-of-pocket premiums did not increase from 2016 to 2017. For those who are unsubsidized, premium increases depended on where you lived. According to a Kaiser Family Foundation report released last week, those premium increases led to the most profitable first quarter of any of the four years of the Marketplace’s existence.

The system is stabilizing. People who claim the Marketplace is imploding often point to the “bare” counties where there may not be an insurance company participating next year. To put that in context, the Kaiser Family Foundation estimates that 25,000 enrollees live in those counties. That is 0.2 percent of all Marketplace enrollees, which certainly does not justify legislation that, for the House bill, would result in 24 million people losing coverage, or for the Senate bill, 22 million people losing coverage.

Moving “beyond the ACA” is difficult for me right now, since I think we are all somewhat myopic in debates on the topic given the Congressional debate. But, I will highlight three areas that I see as possibly being on the table for legislative action.
First, as Gail mentioned, is stabilization. We have determined much of this already in our public programs—in Medicaid managed care, Medicare Advantage, and Part D. This is not rocket science. We know the solutions for market stability, we simply need to apply them. This includes paying cost-sharing reductions which has been subjected to political games. We were sued by the House because they did not think we had the appropriation to pay for it. But, if they wanted to, they could have provided the appropriation in a heartbeat, and the administration could have defended our interpretation of how to pay for it in a heartbeat. I think this is a no-brainer, but the congress and administration have yet to commit the $7 to $8 billion a year to lower deductibles for lower income people.

We hear much about reinsurance, and to a lesser degree, risk corridors. These have become synonymous with an insurance company bailout. But, this is similar to the “bailout” that has created a vibrant Part D marketplace. I do not understand how it can be a bailout in one context and not in another. There has been intense debate about what to do with the individual mandate. President Obama did not embrace the individual mandate during the 2008 campaign. It is certainly not the most popular element in the ACA, but no one has yet defined a better solution. It is the least bad way to get young and healthy people into the system—people who may think they do not need insurance on day 1, but actually need it on day 30, 60, or 90. Resolving this issue will continue to be difficult but is important to stability.

Second is the issue of cost, which the previous panel did an excellent job covering. When we were developing the ACA, we took the kitchen sink approach. We threw everything into the law: regulatory, competition, innovation, and data policy. We were rigorous in implementing what was working, and discontinuing what was not working. This includes testing a public health model for diabetes prevention a few years ago. The results showed that it worked and it could now become a Medicare-paid service next year if we stay on track. Our kitchen sink experimental approach is now being countered by reverting back to a debate where health care cost containment means capping federal programs, deregulation, and the blunt tools that we know could result in lower health care spending, but could also result in lower health care benefits, lower coverage, or nonsensical cuts to provider payment rates.

The biggest tension that I see in cost containment is the clash between freedom and competition. The “freedom plans” championed in the Cruz amendment are essentially deregulated plans. There are no standards to assess actuarial value or to gauge richness of the benefits, and there is no risk adjustment. Thus, these plans cannot facilitate price and premium competition among insurers, which is why insurers themselves call the plans unworkable. This will be a difficult issue for us to grapple with—is our goal freedom and deregulation, or competition and lowering costs?

The third area for legislation beyond the ACA is coverage, which matters greatly in the next hours and days. If you asked me a year ago where the debate of coverage policy in politics would land after the ACA, I would have said it is going to be a debate of how—how do we cover people? Is it a public plan, a public option, private insurance, or some amalgam? Medicaid managed care is a good example of an amalgam of private and public programs. But we are not having a debate about how. Instead, we are having a debate about whether people should be covered, what does coverage mean, and, for example, can $45 billion in a block grant for the opioid crisis compensate for cuts to Medicaid, a program which covers a spectrum of care from prevention to treatment to post-addiction care (to fight relapse). We are in a weird debate where coverage is no longer the currency it was only a short time ago. My hope is that the term “coverage matters,” which the Robert Wood Johnson Foundation made famous about 10 years ago, may have a resurgence in the Senate. I do not think we know at this moment whether we are seeing the end of the Obamacare repeal saga, in which the value formerly placed on coverage will return, or simply the end of a battle in a longer war.

I will end by saying that I learned at least two things from the ACA experience:

▲ Big change can happen. It is not impossible for Washington to do big things.

▲ Dramatic improvements can occur over a short period of time. But, agreeing with Gail, this is contingent on leadership.

Do our leaders want to make the hard decisions so that health care is more affordable, more accessible, and of higher quality? We may know much more about the answer in the coming days.
OUTLOOK FOR HEALTH REFORM

James Capretta

Good afternoon. I am Jim Capretta from the American Enterprise Institute. I did my slides before the events of last evening. Honestly, they are already out of date—even compared to the past 24 hours! In light of the extremely fluid current state of play, I am calling an audible and will speak more globally about the health reform outlook!

I will also note my disagreement with points already made on this panel.

My first main point is that a partisan approach to health care simply does not work. There may be policy areas that are amenable to one party taking the lead while the other party works in total opposition, but this is not the case for health care because of its complexity and the ease with which the changes that are being put in place can be distorted through political lenses and made to look quite different from their actual impact. This point clearly pertains to both parties. Accordingly, I thought it was a mistake to pass the Affordable Care Act (ACA) in 2010 with only Democratic votes and I think it is now a bad idea for Republicans to try to pass something with only Republican votes. I would also note that upon close inspection, the Republican bills are not truly repeal and replacement, but rather an amendment to the ACA.

Where do we currently stand? It is, of course, difficult to read the tea leaves but I believe there is a level of political instability surrounding health care policy that is not going to abate. This is unfortunate since health policy problems do need to be rectified one way or another over the coming months, or years. I do not know how this will occur, but somehow we will need to achieve a level of political stability to gain programmatic stability.

My second main point is that enacting successful policy is nearly impossible when the President and his larger administration have essentially zero point of view on any aspects of the associated policy. To be candid, President Trump was elected without having to say much about which policies he actually wants to pursue, and is even proud of this. He spoke in very broad terms, which somehow helped him get elected. Now in office, we witness the Administration wasting their first six months-plus trying to determine their policy prescriptions on terribly complex issues—all because they did not have a ready game plan or at least the beginning of one. All campaigns are vague, but this one set an exceedingly high mark! The game plan is critical because it gives the public a sense of how they will proceed and it enables the Administration to build momentum and drive public buy-in. You also get extra room to find the legislative votes, which is obviously absent in this case. They may still find a way forward; I want to avoid assuming too much.

A third point I would like to emphasize is the role of the Congressional Budget Office (CBO) in validating the individual mandate. CBO believes emphatically in the individual mandate and that any alternatives will not work. Their analysis of the House bill, in particular, is quite astonishing. They argue that with no other changes in the law—the entire subsidy structure, the Medicaid expansion, etcetera, stays exactly as is under the ACA—if the individual mandate is eliminated, six months from now 50 million people will drop their insurance. This includes roughly 4 million people dropping out who obtained...
Medicaid coverage through a “woodwork effect.” I do not believe these estimates but that is what CBO reports, and it is extraordinarily consequential in their analysis and assessment of the Senate and House bills that the individual mandate plays such a central role. This strikes me as a strange circumstance for an analytic shop to have such a strong view when the evidence base is thin. For the State of Massachusetts’s reform, and now under ACA, I do not believe there is clear evidence that the individual mandate is the only way forward.

Many trumpet the evidence of Medicaid expansion’s national success. First, I completely disagree with the idea that Medicaid expansion is an economic stimulus program. Advocates clearly presumed that ACA would compel all states to expand Medicaid. As you all know, the Supreme Court struck down this provision in a seven-to-two decision—not a close call. As Gail noted, for states that expanded Medicaid, the federal government is financing 90 percent of the costs for the highest income people in their Medicaid programs. Meanwhile, more fiscally-oriented and conservative states did not expand Medicaid and, as a result, their taxpayers are essentially sending federal dollars to the other states. It is an unstable and unsustainable situation that will not last. Second, it makes no sense to have the last person in Medicaid compensated with a 90 percent federal dollar match, while the first (poorest) person has a 50 to 70 percent match. I am not sure how, but adjustments will be made to this unworkable situation.

A final main point I would like to make concerns the discussion of capping Medicaid and the indexation of it to the consumer price index beyond 2022 or 2023. Caps are not a new idea in health care; there are caps in current law. You might be shocked to learn that caps were enacted by the ACA. For example, ACA placed a cap on Medicare’s growth rate. There are actually two Medicare caps. First, there is the Independent Payment Advisory Board (IPAB) cap that restricts Medicare from growing faster than gross domestic product (GDP) plus 1 percentage point—quite a bit more than the Consumer Price Index. If this cap is triggered, IPAB is tasked with proposing new restraints on program spending. Second, from now on, all hospitals will be paid by Medicare for inpatient stays assuming a productivity increase of 1.1 percentage points relative to the prior year. In net present value terms, I calculate that this is a Medicare cut of roughly $4 trillion—the largest in the program’s history—which is a huge amount of money taken out of the inpatient hospital baseline through, in effect, a reimbursement cap.

The ACA also caps premium subsidies at roughly 0.504 percent of GDP. If premium subsidies under the ACA are projected to surpass that level—which they were in the CBO’s original estimate—they would be indexed below their original levels. Another cap in current law, signed by President Obama in a different piece of legislation (MACRA), caps physician fee increases at 0.75 percent annually if they join an alternative payment model. Otherwise, fee increases are capped at a very low 0.25 percent. Physicians who do not agree to join an Accountable Care Organization, but instead practice and take care of patients in traditional settings, will see their fees forevermore grow at no more than 0.25 percent annually. This is a massive cut, especially in present value terms which is clearly illustrated in the 2017 Medicare Trustees Report. Many caps are already in place and are all intended to have similar effects: force decision-making to bring costs under control. I think it would be difficult to make the distinction that a cap in one program is morally reprehensible while in another is morally fine. This makes little sense to me.

* Editor’s notes: James Capretta did not review his slide deck during this presentation, but they are available on the symposium web site. Readers may be interested in this Health Affairs Blog by James Capretta and Joe Antos, “Suggestions For A Bipartisan Approach On Health Care” that was published on August 10, 2017.
Joanne Kenen

I want to begin by talking about costs. One of the things the health reform debate has forgotten is that the “bending the curve” experiments remain—no one is trying to repeal them. There was anticipation that they may try to repeal the Center for Medicare & Medicaid Innovation (CMMI), but I think the Republicans determined that they could benefit from keeping it. MACRA may look a little different under Secretary Price, but there is no talk about repealing it. Consider the debate we had in 2008 versus the debate we are having now. The former was partly about bending the curve (cutting costs), and you could argue how successful we have been. The current debate is more about cutting premiums. How do we return to a more fruitful conversation about cost and coverage, not only premiums and coverage?

Gail Wilensky

I think both discussions are important. How much should we be concerned about coverage, and to the extent we are, what direction should we go? I think it is unfortunate that we are stepping back from that debate. It is not obvious that the majority of the Republican Congress is as concerned about coverage as I happen to be, or others are. I think that how to increase coverage, and the nature of that coverage, are critical questions. There are likely members of Congress that would be much more sympathetic with catastrophic coverage requirements and not broader coverage, and these issues should be resolved.

I very much agree with Jim’s statement, and I assume the other two panelists agree, that it is very harmful when we have major social legislation passed on a single party vote. It guarantees its instability. Jeanne used the Affordable Care Act (ACA) as an example that you can get big things done. Yes, if you happen to have 59 or 60 people in the Senate, you can more easily get it done (though in the end it was not that easy). Consider what kind of ACA we would have seen with a 52/48 division in the Senate. This is the reality of what we must deal with in this country to make change. I think it is fortunate that Republicans did not achieve their wish which was to emulate Democrats and get single-party passage of major social legislation. We are going to have to deal with that, and certainly we must address the cost issue. I have been very supportive of Altarum studies that have focused on the components that drive spending, plus the discussion that I heard in the previous panel. We need to be careful not to get too excited about the success we saw in this country on cost control in the post-2008 period. It is compelling that when you compare spending between 2009 and 2014 versus 2001 and 2009, using the OECD statistics, you see that as much as we dropped in those comparison periods, it was less than all 32 OECD countries. This suggests that the global recession had a very major impact—not necessarily the entire effect, but a very major impact.

It is a telling reminder that this cost issue is not going away. I think the notion that we are going to spend less than 18 percent of our GDP on health care is a political pipedream, regardless of which party is in control. We do need to stop the growth rate we have witnessed during previous prosperous times. We cannot sustain such growth and make the investments that we have discussed to improve the social determinants of health (which I do not think doctors and hospitals should carry out—it is more a question of where we put the money). Those tradeoffs are going to remain with us or even become more difficult to manage, depending on what goes on in the coverage area.

It is just as well that the ACA remains the law of the land until something else is passed. There is no clear indication that a majority agrees on how that something else should look. Also, it is an important question as to how much we
can control health spending growth absent another global recession or a U.S. slowdown. These issues are complicated by the aging of the population and the pressure that will put on health care spending because of the differential use of health care by older populations. We have very serious challenges ahead of us. My concern is: how do we get the leadership to recognize that, while there are different ways of reforming health care, we must find a way to work together as a country. It has been an absolute mystery to me why Republicans thought they could emulate the political strategy of Democrats, and had they been successful, have a different outcome than what they have so skillfully used for the last seven years—bash the other guys over the head unmercifully with anything unpopular about the legislation that they passed.

Jeanne Lambrew

I must take issue with the “emulate the strategy of Democrats in 2009” claim. Back then, Mitt Romney had just passed the Massachusetts bill, Arnold Schwarzenegger was working on health reform in California, and Iowa was also trying to do something—there was significant bipartisan support for health reform entering 2009. Senators Grassley and Baucus did a whole “ready-to-launch” session about preparing for it. We began with extensive momentum in this issue. In March 2009, President Obama hosted a bipartisan White House forum. He ended with a bipartisan Blair House forum. Senator Baucus spent all summer trying to get Senators Grassley and Enzi and the “Gang of Six” on board. Let us not forget that Senator McConnell said that his priority was to make Obama a one-term president. It became a choice between a partisan bill and no bill—something or nothing.

Returning to your original question, I find it interesting that the one talking point from the Congressional Budget Office (CBO) that the Republican leadership has used is that premiums in 2026 would fall by 30 percent. They cling to this data point, but it does not account for higher out-of-pocket costs and fewer older and sicker people in the pool. That is, it is not an apples-to-apples comparison. The important question is what will be in the benefits package. If we believe in a private insurance model—which we can posit about the exchanges—then the only sound approach is good, rigorous, standardized competition with an exchange where people can shop. The research from the first couple of years of the exchanges shows that people are incredibly price-sensitive. They were switching plans much more than we have seen in other programs because they can easily go to a website and choose plans based on price. If we are serious about making this private model work, it must combine a set of regulations to facilitate standardized price and quality competition, along with providing adequate risk stabilization programs. It is poised to provide an important test of whether we are willing to embrace private insurance competition to make the marketplace work. On the horizon, beyond this current debate, we may be reverting to the deregulated freedom plans and a single-payer debate if people are not going to give this middle-of-the-road option a chance.

John Ayanian

First, we need to realize that the issue is not “coverage or cost control,” because it is about both. That was the approach that Massachusetts took, with coverage first, then working towards cost control. Second, we need to separate the short-term, immediate fixes that are required for the marketplaces to function more effectively, and the much longer-term fixes we need for Medicaid. Merging them into one bill, with no hearings and no thoughtful deliberation on both parts, let alone either, hamstrings the potential to move forward in a bipartisan fashion. How the bipartisan cooperation looks on those two pieces may be very different, but we need to separate them and think about what the short and long-term goals are on those major parts of the ACA, both of which could potentially be improved. Putting them together on a very tight timeline had the bill run into trouble and generate significant pushback. For
example, for many Republican governors whose states have expanded coverage, they see very real benefits, and they have become an influential force in the debate.

**Joanne Kenen**

Jim, you have written about premiums versus other aspects of cost, but if you were in charge in 2009, you would not have written the ACA. You have been very critical of it, but you have also been quite critical of Republicans who think that they can ignore the changes over seven years to the health care system and to people’s coverage. You are privy to conversations with Republicans—some of whom are working to uproot ACA. Even as they talk about full repeal, it is not truly full repeal, right? It is about the mandates, the taxes, Medicaid expansion, but not the rules, not the insurance regulations and not the other bipartisan pieces concerning delivery system reform. How do we switch the discussion to something that is more reality-based?

**James Capretta**

I truly do not know at this point. It is going to be tough. On the cost side, many of the folks who worked on the ACA are hopeful and say that they threw in the kitchen sink to reduce costs. In fact, we established an exchange system for a small segment, that is, the non-group market, and we essentially left the employer system alone with the exception of the Cadillac tax. Recall that the President very successfully ran against that tax in 2008. Who was the President to tax health benefits for the first time in history? It turned out not to be President McCain, but rather President Obama, having run against candidate McCain on that idea. They included the Cadillac tax but never liked it and they worked to repeal it. Now it has been delayed to 2020 and the Republicans will probably delay it further. The employer system is not facing much discipline. It has an open-ended tax subsidy and that is going to continue because there was never buy-in on how to bring discipline to it.

Medicare is a much larger factor in determining the overall structure of the delivery system and its costs, and how the health system evolves. Yet the Medicare provisions under the ACA are quite minor. There is much talk about accountable care organizations (ACOs), but the vast majority of them are bonus only. Who would not do it? You get a bonus if you save a little money by forming an ACO and there is no downside risk. They take the money now but will never take the risk. The entire design is flawed, and it too is a minor event in the scheme of things, perhaps a couple hundred million dollars. It may have actually cost money rather than saved money. For effective cost control, far larger initiatives are required. You either have to inject much more market discipline into the system on the two places where we do not want to do it—the employer-based system and Medicare—or you can have the government take it over with a so-called “consolidated buyer side.” I think we know what that means: the government will tell you what it is going to pay. The country has to grapple with this. Given the resistance to true market-oriented discipline, one would probably bet that the government option is more likely to happen eventually. That is reality-based if I had to put it that way, and I do not think either the Republican or the Democratic Party is prepared to deal with that.

With respect to the goals of coverage, I agree with Gail. There is a fundamental problem on the conservative side, which is that they need to come to grips with the fact that people should have health insurance. There is nothing wrong with saying that. It is not that hard! That does not mean that every taxpayer is on the hook to subsidize every person’s health insurance, but people should have health insurance and the key question is divvy-up personal and social responsibility to make it happen. They can disagree with their Democratic friends on how to do it—and by the way, there is still going to be a large number of uninsured under the ACA—but the country now accepts this proposition.

**Joanne Kenen**

In the scenario Jeanne described in 2009, two things were happening. There were bipartisan conversations that were serious and lasted for months. Senator Baucus tried. There was also a small group in the Senate talking to each other. Months of words with no agreements. The House was more partisan from the beginning. At the same time, there was considerable anti-Obama rhetoric, for example, “his Waterloo” and “make him a one-termer.” Health care has been a political issue since before any of us were born. We now have mountains of polling data showing that your view of the ACA, even if you are personally covered by it, reflects whether you are a Democrat or a Republican. If you are a Democrat you like it (you do not necessarily love it), and if you are a Republican you hate it. We are stuck there. I think all of us could readily develop ideas for improvement—RWJF did this by putting actuaries in a room to develop solutions.
They called it the Actuarial Challenge and Politico called it the Wonk Olympics. If I locked up any of you, eventually you would find common ground and chart a path forward. Instead, we are beyond stuck. We do not know what will happen in the next few weeks, but what if the problems in the ACA are not fixed? The previous administration tried to address these. Some of the governors, including Republican ones (for example, in Alaska), tried to address problems in their markets. If there is no legislative action, even if the Trump Administration does not end the cost-reduction subsidies, how much TLC does the ACA need to function in 2018?

Jeanne Lambrew

Significant time spent with my former colleagues demonstrated that you have to actually run the exchanges. Those states with their own marketplaces run their exchanges. There is a team of experts at the Department of Health and Human Services who run the federally-facilitated marketplaces. My anxiety concerns the ambiguity on decisions by the Administration as to whether they will carry out current law. Put aside Congress. It goes beyond paying the cost-sharing reductions. Will the Administration continue on the pathway that was created? In the last year we worked diligently on an automation project. We tried to put everything on defaults so that our successors would not have to do much. Instead, they are removing elements and making things harder. We saw guidance last week that would kick more people out of the marketplace that likely is not consistent with the statute. I say this because at some point there must be a decision by this administration that it is going to be, at a minimum, a caretaker, and at a maximum, an owner that can steer the marketplaces towards a policy direction should it desire to do so. Absent these actions, I worry about what will happen next year.

Gail Wilensky

Do not hold your breath for that to happen! Perhaps you can get a more benign neglect approach on the marketplaces. Again, the majority of newly insured have nothing to do with the exchanges. Rather, they are on Medicaid, and keeping Medicaid functioning is important, although I think ultimately it is not in a long-term, stable position and that issue will have to be resolved. While it would be desirable to have explicit decisions about their attitude on the exchanges, if you think there is any likelihood of the Trump Administration actively trying to support, financially or otherwise, the exchanges—forget it. Can they continue to function? Most of them will and that is fine for people to be able to buy into them. It does not ultimately help us decide what kind of a program we want, and as Jim had mentioned, there will still be a significant chunk of uninsured individuals. Indeed, it is hard to imagine that the number of uninsured will not inch up for a number of reasons. For those worried about coverage, that should still be a major concern. There are important questions with regard to spending elsewhere, and, in particular, what will happen with Medicare and the implementation of MACRA. Building in a spending rate that is as low as MACRA is for anybody who is not part of the alternative payment mechanisms—most of which have not been shown to save money—is problematic. This is not surprising because most physicians have not entered into two-sided risk ACO arrangements, although they will need to work at this if they expect to sway the alternative payment mechanism in their favor. There is a problem with a strategy that builds in as low an increase as what we have seen in MACRA, although that, of course, does not comprise total physician spending. That is only at a unit base and it is harder to judge how it all will transpire. But there is a problem when you do not have sustainable spending that is anywhere near what the cost is likely to be for the physician portion. It is an improvement over where we were, and I am glad MACRA was passed, but I think we need to focus these payments and on finding metrics that are able to be used by physician practices more broadly.
Beyond the ACA: Health Policy and Sustainable Health Spending

Audience member
Consider the American expectation for a health care package and how much it should cost, and it is set by the private market and Medicaid. In Medicaid, they are trying to pay 30 or 50 or 70 cents on the Medicare dollar, depending on what market you are in. The only area we are targeting now by Congress seems to be where you can squeeze the least out. A more honest baby-step approach might be to cut the Federal Medical Assistance Percentages (FMAP). We raised the FMAP during the recession. To see how much you can cut Medicaid, drop the FMAP by 2 percentage points and maybe put half in a lock box as a rainy day fund. That would be a more honest dialogue and it would be easier for the governors to calculate. They would not have to model this 30 or 40 percent cut.

Gail Wilensky
We know where the money is. As Jim said, it is in this $260 billion tax subsidy that goes to employer-sponsored insurance. You already know the answer to the question you just posed; we pick on Medicaid in large part because we are willing to. We could pick on Medicare except the politics of pushing around the elderly make most politicians cringe, appropriately so. We do not want to consider—and the “we” is Republicans and Democrats equally—reducing the very inequitable and inefficient way that we subsidize employer-sponsored insurance. That is unfortunate. It is a big pot of money left on the table, and there is no indication that Republicans are ultimately going to impose the Cadillac tax, which is a clumsy approach, but is better than nothing. They will probably keep kicking the can down the road as long as necessary, which is a shame.

Jeanne Lambrew
This debate has highlighted an interesting aspect of Medicaid policy. Unlike the federal government, which does not have to revisit Medicaid policy each year, governors often face difficult cost problems and wonder how they will manage their budget for the next year or two (depending on their budget cycle). That model has contributed to the excessively low provider payment rates. At the same time, looking at our longer term trends (to Darrell’s point), we are spending a significant amount of money on our health care system. Just because it is 30 or 50 cents on a Medicare dollar, is that too low? It is interesting watching governors who have assumed more ownership of these programs than has Congress. Fast forward to Medicaid expansion and our work with Michigan Governor Snyder who then faced the Flint water crisis and its consequences. Having that problem-based, regular touch on programs is a good way to keep things in check, though not always. We have learned many positive lessons from these last six months, because the governors have stepped up to the plate defending Medicaid because of the structural reasons.

Joann Kenen
I think the politics of Medicaid are changing. In the House, the issue was preexisting conditions, but in the Senate the issue was truly Medicaid.

Gene Steuerle
Here is a softball comment pulling together a few themes. At all of these health policy forums, I wonder if events happening outside of health care will finally change the world or the way we make decisions. I refer to comments that Stu mentioned on income growth and affordability. From my own and Charlie Roehrig’s work, approximately a third of all per capita income growth from about 1990 to 2007 was health spending growth, which most of the public do not count as income growth. From 2007 to 2017 the figure is 60 percent. You can blame it on the recession or other factors. Due to low economic growth, CMS projections estimate it at another 50 percent. All this money, relative to meager income growth going into health care puts enormous pressure on the system to adjust (whether it adjusts well or not) and actually change the dynamics of health care from what we have been through the last two or three decades?

James Capretta
I could not agree more. First, as you emphasize, too much of our income growth goes to health care, and there is not enough left for other goods people want to consume. Second, income growth is too low—the overall pie is not growing fast enough. Two percent growth (CBO’s baseline is at 1.9 percent) in the medium term, is simply not enough. Far too many financial commitments have been made by
federal, state, and local governments based on assumptions of 2.5 to 3 percent growth. We have been stuck at 2 percent for roughly 15 years, and something has to give. I do not understand politics—I threw my prediction card away last year like everyone else. Nevertheless, people want higher income growth; that is fundamental to everything. As far as health reform, I find it unlikely that we will achieve higher income growth under the current arrangements. Something would have to change to improve the situation.

Jeanne Lambrew
Two points. First, listening to John’s discussion about Massachusetts—first do coverage first and then cost—we tried to learn the lesson of how important it is to do both. That is why we put so much emphasis in the ACA on different cost proposals. Every day, it was on my to-do list, equal with coverage, for my reporting of metrics and accountability. We certainly tried hard. It is hard, though, especially the question of whether there is a single bullet, one critical theory, or is there something essential that works regarding provider payments. I think that the previous panel attests to the fact that we are not sure what happened in the past five or eight years. We have to understand that phenomenon and determine what cost control initiatives are working to make them systematic. I am a little worried that without the care and attention and hyper focus on what works, our cost trends will begin to kick back up.

John Ayanian
From my clinical perspective, I think we have to change the fundamental incentives for providers. This goes back to the points Darrell made—trying to control costs with our current payment mechanisms for hospitals, pharmaceutical manufacturers, other intermediaries, clinicians, and others is not going to achieve the bending of the curve that is required. We need the government to set targets about what we as a society are willing to spend, but then allow great flexibility for states and provider networks to implement those targets as they choose. We will likely see different approaches to implementing those targets, and that will provide natural experimentation that we can evaluate and learn from. If we keep the current, prominent fee-for-service system—as was discussed in the other panels—it will be difficult, if not impossible, to bend the cost curve. We know that providers can respond if we change the incentives and focus on capitation or global budgeting or bundled payments. Different health care areas may choose different approaches, but I think that is where we need to move.

Gail Wilensky
It is going to be very important to have leadership in this health care debate. It is doubtful that it will come in the political world; this would be a good time for the leadership in the clinical world to step forward and help define the potential for change in the areas, such as those John discussed, and also the appropriate metrics to use in judging outcomes. This truly does require clinical leadership. We will have to let the political world develop as the country and the people see fit.

Joanne Kenen
On that note we will close. I think this is my sixth year at this event which is amazing. The one safe prediction we can make is we will be back next year talking about the unsustainable trajectory of health care spending and partisanship in health care politics!