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Session 4:

Tools for Change

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Session 4: Tools for Change

MR. HELLMAN: Ladies and Gentlemen, it's Friday afternoon. Everybody has plans or at least some do. Perhaps we can begin.

I am the moderator for this group of two somewhat separate panels. And so, the way this will work is Meredith Rosenthal and Michael Cannon will be the first panel. We'll have limited questions then. Then, we'll have the second with Kate Baicker and Bob Reischauer and then full questions.

Taking the prerogative of being both a Brookings trustee and the moderator, I wanted to make a few comments. And these comments are not so much on tools for change but on the practice and potential of medicine, which is the title of this day's discussions.

In my business, you are required to disclose your potential conflicts of interest, and so I'm used to do that, and I do it now. I prefer to think of them as not conflicts of interest, but points of view. But, you can take them for whatever you'd like to take them for.

So, I'm an oncologist. I am a basic and clinical researcher, and my career led me to have a number of academic leadership positions that you can see here. And perhaps one that's directly relevant to my point of view is I worked in international health service, Great Brittan in 1965 because I was sure that it was coming and wanted to learn something about it. So, you can see how prescient I was.

But anyway, it's -- part of my disclosure is pertinent to this. In doing that, I also have a number of industrial relationships, which give me a point of view on this whole subject. I'm on the board of directors of two treatment device companies, one of which, Varian(?) Medical Systems, dominates its market. It makes half the world's radiation therapy machines and 70 percent of those that are in the United States. So, it's a formidable company in that manner.

And I'm on the board of Inside Tech, which is a start up, making a completely -- a method of completely noninvasive surgery and facing the regulatory difficulties of getting this potential advance into the marketplace. I'm also on the scientific advisory board of a gene therapy company, all involved with cancer.

And finally, and relevant to some of the discussions today, on the board of directors of a company, Vantage Oncology, which is trying to put practices into the communities which follow the kinds of practices that occur in academic medical centers with regard to quality. And one of the main points of it is all information is transparent through the whole system, and all practice guidelines are similar and are monitored.

So, those are my disclosures. I am a cancer doc. And I want to say a few things from the vantage point of cancer, which I think is relevant to all

the major chronic diseases. And by major chronic diseases, I mean coronary artery disease, stroke, chronic renal disease, diabetes, multiple sclerosis.

First of all, while cancer has a bad name, it is the only curable one of the chronic diseases. It's worth thinking about. And their cure rate, at least as defined by five year survivals, which while not perfect are definitely correlated to long-term continued survival, not absolutely but close.

They've gone in practice, since I've been in this business, which as I said, is 47 years, from 33 percent to better than 55 percent. So that's something nice to be proud of, but it leads you to believe and understand that this is half way technology. We're changing all the time. There is no standard of care.

And I would suggest to you there isn't or shouldn't be for any of the serious chronic diseases because we don't do well. When we get penicillin for strep throat, a parallel to that in the major chronic diseases is then you can begin to have a standard of care. We do not have a standard of care now. And it is difficult to do that.

I was going to say two things that you should understand. The country, while we're all concerned about costs, is very committed to curing cancer. We have the federal – I think it's the only time that Richard Nixon and Ted Kennedy agreed, and that was in the joint approval of the National Cancer Act of 1971.

There is unanimity on this matter and willing to put significant amounts of our public expenditures there, not of a limited healthcare budget, but significant amounts of our current expenditures. And I say it that way because the National Cancer Act made the National Cancer Institute a autonomous part of the National Institutes of Health.

So, what are the hurdles that I see that I have personally been involved with in this one? And these are in research. There aren't very many hurdles, except limited funding. And the government until quite recently has really been very generous in its support of cancer research, and I presume it will continue to be, although we're having a bad patch right now.

Regulatory process is extraordinarily difficult. The FDA is, in my judgment, inordinately risk averse. It's one thing to be talking about over the counter medications for the treatment of constipation and quite another to be talking about cancer therapies or multiple sclerosis treatment. And this distinction is very poorly made and a tremendous impediment in taking the potential of medicine and putting it into practice.

Second – and it also has the problem that it costs an inordinate amount of money to go through the regulatory hurdles. And if that's the case, all your small companies that have a bright idea and some initial clinical results cannot get forward unless they make an arrangement with big pharm or big device

companies, depending on which one their in. And those companies have their own problems, and they are reasonably risk averse.

So, there are lots of ideas that are sitting there that have, in fact, good early clinical data, that get stuck. And a consequence of this is, I think, unreasonable pricing. But I understand why it's so, but it is so, the new idea. So you get drugs that are coming out at fantastic prices. You get return on investment for fixed equipment of less than a year, where the equipment is going to be good for 10 years.

So, I mean but you understand why it occurs. And it's greed as well, but it is a significant issue here. And of course, the payer problem. We've heard about bread payers(?), but from getting these things going is you can have FDA approval and a device which looks great or a drug that looks great, but if the payers won't pay for it, you can't do anything.

And the payers are not organized. They're individual payers. You've got to go individual markets to do this. There are tremendous hurdles. And this has not been talked about much today. There are significant hurdles to bringing new things to the market in this country, much more than in Europe. But nothing goes in Europe that doesn't go in America. This is the major healthcare market. If a company can't make it in America, it doesn't make it.

And then you heard a little bit about individual care, but I would commit to you there's personal care too. You can't very well have guidelines for, let's say a disease I treat and take care of all the time and that's breast cancer, because within those guidelines, there are so many individual variations. One woman's breast cancer, even if the stage is the same, her personal preferences are co-morbid conditions or logistics between where she's going to be treated area all different. And they influence what you do. So, having guidelines and trying to use those for pay-for-performance is going to require much more skill in my judgment than is currently available for this.

And just a few comments and then I'll quit. This is Tuesday's New York Times. As Law and Order says, ripped from the headlines on Tuesday, front page, well, there's performance based bonus in Medicare. You all notice that it was just a little bit over the fold, so that's pretty good. For something like this, you don't expect to see that.

And then you go to science times. You remember that section occurs every Tuesday in the New York Times. My wife always grabs it and I didn't see this one until I was much later in the day. But there's Larry Altman, who's a senior colleague and publishes his occasional column, Doctor's World, and he's talking about individual patient care based on management derived from

clinical wisdom and comparing that in a – as I say a nostalgic way with evidence based medicine.

Well, you can't have one and the other. They just are completely unlinked. Evidence based medicine goes from pay-for-performance. Clinical wisdom, it's very hard to figure out how that fits into this system. And it was kind of interesting to both see those the same day.

So what have I learned about – in this 47 years about current treatments or chronic disease? One, halfway treatments are what's expensive. Definitive treatments are cheaper. Halfway technology is what we have in all the major chronic diseases today.

The person who gets a major procedure for coronary artery disease increases their risk of having a problem with time, not decreases their risk of having a problem with time. It is very expensive. You can think of, of course, kidney failure, and the solutions we provide are halfway solutions. You know, a kidney transplant is hardly a solution. It's what we have today. And the same things can be made for cancer.

So I leave you with two daughters of Asclepius. I'm sure you are all familiar with the two daughters and their operation, but they were Hygeia and Panacea. And their names speak to what they were. I'd like to say they're both

cheap dates, because the panacea isn't really that expensive. But if you have Hygeia, you don't need as many Panaceas.

And we have no mechanism in our current healthcare system to pay for good preventive medicine, because of the comments made earlier about cost shifting to Medicare later on. It's not so important to provide as initially if Medicare is going to foot the bill later on. And the underlying philosophies for Hygeia are utilitarian, classic utilitarian theory. You don't have any doctor patient relationship there. You have the population versus provider relationship. It's much easier.

So vaccinations questions are utilitarian questions. They're not individual questions. But that's not true for a treatment for Panacea. That requires right space philosophic approaches.

The payer – I'm not going to talk about this one. I think I'll leave it. We did talk about this relationship. The one point I want to make is that what the patient wants, at least in cancer, is to be returned to their pre-morbid state, not to have some fixing, which gives them a new morbidity or a transient fixing, a fixing to the pre-morbid state without new problems for them to deal with. And they're willing to see a greater investment for that than for a halfway thing. The paradox is it's the halfway that costs more.

Those are my comments, and now I'll go back to my official chore and introduce to you our first two speakers and then allow them to speak. The first one is Meredith Rosenthal. I'll introduce both of them first and then they will get up.

Dr. Rosenthal is an associate professor of health economics and policy at the Harvard School of Public Health. She received her PhD in healthcare economics at Harvard as well. Her principal research interests are around economic incentives that influence consumer and provider health decisions. And she is currently working on projects that examine trends in the health insurance market, pay-for-performance, tiered networks, and consumer directed health plans.

And our second speaker is going to be Michael Cannon, who is the Cato Institute's director of health policy studies. He has formerly served as domestic policy analyst at the US Senate Republican Policy Committee under Senator Larry Craig, where he advised the senate leadership on health policy. Most recently, he coauthored the book *Healthy Competition: What's Holding Back Healthcare and How to Free it*.

Meredith?

MS. ROSENTHAL: Thank you, Dr. Hellman. And thank you, all of you who have stuck through with the entire day here. Actually, this morning as

I was sitting in the audience with the first panel, I was beginning to break out in a cold sweat over standing up after those folks. So, it's nice that the room is half empty. I can at least convince myself that you're hot as threatening.

So, I'm going to talk to you about pay-for-performance. And I'll keep the sort of preface about the extent of pay-for-performance and what it looks like today relatively brief. Looking around at faces in the audience, I know many of you are old hands at this. But let me just say a few words.

This morning many of the talks, if not all of them, referenced the Institute of Medicine's Crossing the Quality Chasm, the report that came out in 2001, that really – it didn't generate any new evidence around the quality problems, the problems in value and efficiency of care, but really consolidated a lot of evidence in a really striking way. And physicians were not the only audience for that report. Large employers, who we've not talked about very much today, employers were very motivated reading that report.

Employers like folks at GE, Boeing, and other large companies that spend a substantial amount of money on health benefits, really took that report to heart and said to themselves, why are we not doing purchasing in healthcare the same way we purchase everything else in our business? And so there was a kind of sense to that.

And without sort of making the critique about whether or not one can compare buying auto parts to buying medical care, there was a certain sense to some of the recommendations in the Institute of Medicine's report and in particular the recommendation, one of many, that the payment system should be better aligned with at least what we know today about what is high quality care as well as what is efficient and patient centered care.

And so in the last five years, we've really seen a dramatic growth in pay-for-performance. There are inventories around that have documented well over 100 paper performance programs across the country. We did a national survey last year and found that half of HMOs were using pay-for-performance to reward either physicians or hospitals or both. And so, pay-for-performance, you know, I think unlike some of the other concepts that we've talked about, including electronic health records, consumer directed plans, paper performance is actually very widespread and fairly far along in terms of penetrating the commercial market.

And so, what are the characteristics of these plans? Well, the plans that are using pay-for-performance, they do tend to be HMO plans and particularly those that, as I think of them have, the way they contract, associates payment with an accountable physician. And in particular, either they're using capitation payment and so therefore, there's sort of a budget for an individual or a

population to a specific provider who is then accountable for that population or there's a gate keeping arrangement.

So, it's very clear when you go to see did Ms. Jones get her mammogram, who indeed was supposed to be responsible. Now whether that accountability is the way clinicians would think about accountability I think is perhaps an important question. But at least from the health plan's perspective, there's a contractual accountability there. So not too surprising, we see pay-for-performance more often in those settings with that kind contractual accountability.

And I should remark – I'll end up talking a little bit about Medicare, but that's very much not what the Medicare system looks like, as we know, just a very open system, where physicians don't really have ownership of a patient population.

And another important – regionally, pay-for-performance is really everywhere except in the south, again, where the organization of managed care looks very different from the rest of the country. But one important factor we found was that those health plans who themselves had performance contracts, that is, part of their pay depended on how well they scored on their own hiatus(?) measures, for example, those are the plans most likely to do pay-for-performance themselves.

And so I think the theory that there's something being driven here by purchasers, maybe not individual consumers are aware of this, but the employers who are purchasing health benefits on their behalf are really driving a lot of this movement. And it's really those enlightened employers that I mentioned before. I guess enlightened is a term of – a normative term. So I think of them as enlightened, but you may not.

So, the programs today, they're very experimental. They're very early. So, most of these programs focus on physicians. And to begin with, they were very much focused on primary care in large part because there was fairly good consensus on at least a rudimentary set of quality measures for primary care.

And so these measures have been developed over the last decade or so, things like appropriate cancer screening, appropriate immunization, that sort of thing. And so most of the pay-for-performance programs, they set aside a small amount of money, say five percent of payments, and associate that with performance on a handful of measures, five to ten measures at most, largely again, preventive care measures. And this is sort of the way the programs have started out.

All of this is beginning to change pretty substantially. However – oops. These are my own slides. Sorry. Let me take one quick peek. That's embarrassing. Okay. There we go.

All of this is beginning to change, however, as pay-for-performance is looking to have a much greater impact. The health plans that are doing this and some employers directly incidentally are doing pay-for-performance; they're moving it out much more towards the specialists and hospitals. Because of course as we all know, while primary care might have been the place where measurement was easiest early on, in fact, many of the concerns we have, particularly with regard to costs and overuse, which I think is beginning to drive many of these programs, is really in the specialty procedural sector as well as hospitals.

And in addition, where I mentioned earlier that programs are really focused initially on these fairly well established primary care measures like cancer screening, underused measures as we call them, they're increasingly looking to cost efficiency measures, information technology, and also intermediate health outcomes, in particular for diabetes care, for example, blood pressure control, hemoglobin A1C(?) control, I see this again as trying to get much more meaningful than they have been to date.

And so, while these programs are relatively new, of course, pay-for-performance had been tried in healthcare before. There are some good examples of much older programs, the old US healthcare program that rewarded primary care physicians for the same kinds of preventive care measures as well as

health partners in Minnesota, the Hawaii Blue Cross Plan, most of the – most of these programs are quite new and are just beginning to be studied.

There are only a few really rigorous evaluations out there. And right now, they're quite mixed, and many of the studies have only one or two years of follow-up. And so, I think the questions they raise, you know, we can't really look at the studies and say paper performance has no role in transforming the health sector. Because as I mentioned earlier, the pay-for-performance that we see now, it's very much a first step.

These programs, I believe, are rolled out in such a way that they were politically feasible, they used agreed upon measures and small amounts of money, and were often rolled out to those providers who were most prepared to contract in that way, again, those capitated primary care groups, multi-specialty groups. But, as pay-for-performance grows and as payers and the employers that are ultimately footing the bill for health benefits become increasingly concerned about seeing some results, I think we'll see a lot of changes.

And so, in my view, the evidence we have to date is beginning to hint about what's effective. There are some studies that find relatively little effect, some studies, like the recent study in the National Health Service that shows some evidence of gaming, some evidence of unintended consequences of these payment systems, things we should all be conscious about.

But it doesn't really tell us yet whether pay-for-performance is going to be really fundamental to driving the kinds of reforms that have been talked about today with regard to the adoption of electronic health records and broader clinical integration.

So in my view, just looking out answering what is the likely outcome of the growth of pay-for-performance with regard, again, to broader health reform, well, I think it depends on a number of factors. And I would say first, the programs are evolving substantially in terms of their technical aspects. And one is I think that there's much more concern today and there needs to be more concern about thinking really what we're trying to do. If, in fact, the goal is to get small practices, for example, to invest in the electronic health records, recognizing the costs that Dr. Lee was talking about earlier of what those systems will likely incur on those practices.

It needs to be part of their worth system. A one or two percent bonus on fees from a small payer, for example, isn't going to go very far towards building an electronic health records system. And so there needs to be some consideration of balance. I think that they should be sort of commensurate with the costs of improvement. It's not necessarily clear that any one payer should be paying the whole cost of adopting these systems, but they at least need to be in some proportion.

Another thing that programs to date have not done so much is really thought much about giving incentives to providers that today are not performing very well. So these programs tend to get rolled out in broad networks. And as we've been talking quite a lot about today, there's quite a wide variation in the performance of providers. And those that are performing nowhere near that gold standard often have very little incentive to improve because they're simply too far from the target.

So, maybe there are other strategies such as building in rewards for improvement. Maybe there are nonpayment strategies that are needed to bring those providers who maybe have little resources for things like electronic health records, maybe those strategies need to be thought of.

I guess I'm not quite as free market as the panel before me. But the notion of simply putting pay-for-performance in place where it's likely to reward certain kinds of groups and not others and saying that's okay, that's the market working, I'm not quite that complacent. And I think some thought needs to be given to that end of the market that really needs at least to be helped to move along for some period of time.

And I think again, there's considerable concern, I hear at least, among physicians that if we reward these process measures, which are often the case in these pay-for-performance programs -- again, they're sort of

noncontroversial measures such as childhood immunizations -- that if we reward these little pieces, that in fact we'll really take away from physicians thinking about the broader patient, from concentrating on those things that are not easily measured. And I think that's a real concern.

And the development of better capacity to measure health outcomes, patient experience, and integrate those into pay-for-performance, I think could dramatically improve these programs. Although, the concern about using those real outcome measures, of course, is adequate risk adjustment, adequate adjustment for patient behavior, that sort of thing. These are all, of course, balancing concerns. But I think a move in that direction and particularly with regard to cost as well, bringing that into pay-for-performance, could dramatically change the capabilities for pay-for-performance.

And speaking of cost, in my view, it's been five years since cracking the quality chasm and employers, I think when they got into pay-for-performance and pushing their health plans towards pay-for-performance, they had quite a lot of faith that improving quality would result in lower costs. Well, whether there's a causal association there or not, we've seen the health spending trend continue to go up at fairly high rates. And so, I think the time has come and the health plans certainly tell me that they are getting considerable push back from employers about well, why am I paying more and more for this; can you

show me what we're getting; is there any evidence either of improved outcomes or improved costs or ideally, of course, both.

And so that's really leading these programs as I showed before to begin to adopt efficiency measures. Sometimes they're not so controversial; they're things like generic substitution. But sometimes they really are above total cost per episode, and there's concern about appropriate risk adjustment, appropriate measurement there. And while I think affordability, to me at least, is one of the central quality questions that we have, if more and more people are uninsured, population quality is clearly declining.

I think there's a real risk here, a real tension with the credibility of these programs, the legitimacy of these programs as quality improvement mechanisms as the tension against their emphasis on costs. I think it's going to be an important tension to resolve, again, because I think in the absence of any cost savings or cost mitigation, all of this is likely to go out the window.

And then finally, Medicare's role is going to be really important here, and Dr. McClellan spoke very eloquently about all the activities that Medicare is undertaking. And in fact, it has done quite a lot not only for Medicare beneficiaries but for the commercial world in producing a lot of new performance data that can be widely used and in developing those quality

alliances around which commercial payers are also gathering and physicians' societies as well to develop consensus measures.

The one central idea here is that in this fragmented system where in many places maybe there are only two health plans, but most of the providers that I know have 20 or 30 payers, then if they're all doing their own thing or some of them are doing pay-for-performance and others are not, the effects are likely to be diluted. So there's purely private collaboration going on in some markets. And I think it would be interesting to discuss with some of the antitrust lawyers some of the implications of those collaborations.

But also, Medicare has a role in forming sort of a focal point for pay-for-performance, and that seems entirely likely to happen in the case of hospitals for example, with the hospital quality alliance data. I would expect ultimately that Medicare would begin paying on those data, and I can see no reason that commercial payers would do anything other than follow Medicare's example.

On the physicians' side, I hate to be too pessimistic, but it is very difficult to imagine how Medicare can feasibly measure performance at the individual position level, which is the only unit that today it looks at. And whether some of these ideas that were discussed earlier this morning about developing virtual networks of physicians to hold accountable comes to fore

seemed very critical to me in asking the question will any of this really matter for physicians.

Commercial health plans are in much the same place that Medicare is with regard to implementing really effective pay-for-performance. There's a limited amount that one can do when many physicians are in solo or dyad practices. And it's really not clear what kind of data one can collect.

I think the best hope perhaps is using the all payer data sets that have come together through pilots like the Ambulatory Care Quality Alliance Pilot. But even there with the all payer data, there's a somewhat limited opportunity. I'm sure there are some clever ideas about how to get around that, but again, in terms of Medicare's role here, I see great promise on the hospital side, on the agency side, clearly, Medicaid, and nursing homes, Medicare, and home health agencies. There's a lot of logic to moving that model forward in a fairly powerful way. On the physicians' side, I think it's much, much less clear.

And ultimately, I think one interesting notion here might be if Medicare could find a way of measuring physicians at a reasonable level of accountability, whether -- looking at the data very much in the way Elliott Fisher was talking about this morning, which is to say look, there are physician practices that are all along the spectrum.

And right now, under the sustainable growth rate mechanism, basically the rich are getting richer and the poor are getting poorer, could there be a mechanism under pay-for-performance that could allow us to throw the SGR out the window, which nobody mostly I think endorses. Could we do that and use efficiency at some reasonable level of accountability as a way of driving some reasonable cost control in Medicare, which clearly has to be done through some mechanism.

So that's what I see in terms of the potential of pay-for-performance. I think there's a lot of potential upside, a lot of questions about the specifics of how it's going to be implemented. Thank you.

(Applause)

MR. CANNON: Thank you. Thank you for sticking around for the economists after the doctors and the lawyers. My name is Michael Cannon. And there's a lot of enthusiasm about pay-for-performance especially with the late night legislating that Congress did a couple of days ago where physicians are now going to be required to report on their performance according to certain quality measures if they don't want to face a pay cut.

And I share some of that enthusiasm. I think that it's particularly appalling that we have payments systems where purchasers generally in Medicare in particular shovel money out the door without much regard to quality. But

when it comes to third party purchasers creating provider focused financial incentives that are designed to promote high quality care, I think we have to be particularly cautious. Because those efforts have the potential to improve quality in many instances, but also the potential to reduce quality and access for others at the same time. And those difficulties I think are even heightened in the context of Medicare.

So, what I'd like to discuss are three things: first, some of the difficulties involved with provider focused pay-for-performance efforts; second, how those difficulties are heightened in the context of Medicare; and third, how we might reap the advantages of pay-for-performance within Medicare, while minimizing the potential for harm.

So, the first problem, as I see it, confronting any pay-for-performance scheme is that of having a purchaser, essentially a bureaucracy to define quality. And quality has multiple dimensions and is often highly subjective, which makes it very difficult for any distant decision maker to come up with a uniform definition of quality for a large and diverse population.

Now, clinical trials may reveal that an intervention reduces mortality for the average patient. But that average benefit is not uniform. It's not uniform within the trial. It may conceal no effect or even harmful effects within

the trial. And such effects become more likely when we move from the trial subjects to the general population.

And once we reach that level, we find that the patients not only respond differently to the intervention, but they don't value the benefits of the intervention equally. For some patients, the costs of the intervention, for example, a drug's side effects, may outweigh the benefits. And for other patients, they may be taking a number of prescriptions for multiple co-morbidities. And the clinical trials usually tell us little about potentially harmful interactions.

So in these situations, the same pay-for-performance incentive that encourages the provider to provide quality care to the typical patient, instead promotes low quality care for the atypical patient.

The second problem confronting a pay-for-performance scheme in provider focused financial incentives is how to create financial incentives that cause providers to change the behavior but only in the desired ways. One way the providers can meet the performance goals is compliance. Do exactly what the health plan wants you to do. Another way is avoiding patients who make it harder for providers to meet those goals. And that response reduces access for some patients.

Another way of meeting performance goals is to lie. Studies have found that 50 percent of physicians will deceive – do deceive third party payers

and 70 have said that they would do so under certain circumstances. So it's not hard to imagine ways that providers could do the same with regard to pay-for-performance measures. And such deception is very difficult for purchasers to monitor.

Now, the trouble with pay-for-performance within Medicare is that each of these difficulties becomes even greater when trying to implement pay-for-performance within Medicare. Traditional Medicare covers many more individuals than any other purchaser does. So, right there, any perverse incentives that might occur in a Medicare administered pay-for-performance program would automatically harm more people.

In addition, Medicare enrollees are sicker than your average patient, so that they have higher rates of co-morbidities, which makes each enrollee more likely to be harmed by those sorts of perverse incentives.

And finally, Medicare would take longer to create – I'm sorry – to correct any of those perverse incentives, because Medicare is notorious for being slow to correct errors in say its payment system, and I think that we could expect the same sort of efficiency when it comes to any perverse incentives that CMS administered pay-for-performance scheme might create. And so those sorts of perverse incentives would live on in Medicare long after a private purchaser might have corrected the problem.

Given the likelihood that a CMS administered pay-for-performance system would crowd out pay-for-performance efforts, I think that it's those unattended consequences would even reach beyond the Medicare population. Now, it makes Medicare an attractive tool for advancing quality is that it has market power. I mean it's the very fact that they have – that traditional Medicare has 37 million patients in there and so many providers rely so heavily on Medicare payments for their incomes.

But what I think this – what – this view that we should therefore be looking for Medicare to lead the movement towards pay-for-performance, I think what that view overlooks is that Medicare's market power derives from the political power of providers and seniors. And we can glimpse how that political power is likely to affect a CMS administered pay-for-performance system just by looking at the recent history of the sustainable growth rate, where the physician lobby has held off reductions in their payments for I think four years now.

In fact, providers influence is such that Medicare's trustees report – the Medicare trustees report openly acknowledges now that its spending projections are unrealistic because by law, those estimates must assume payment cuts that providers would never tolerate. Medicare's chief actuary, Rick Foster wrote in his part of the last of trustee's report, "While the Part B projections in this report are reasonable in their portrayal of future costs under current law, they

are not reasonable as an indication of actual future costs. Current law would require physician fee reduction totally an estimated 37 percent over the next 9 years, an implausible result.”

So, implementing a pay-for-performance scheme requires a number of steps: finding quality data that relate various inputs to outcomes; translating those data into performance measures; making allowances for atypical patients; targeting, calibrating, and continually adjusting both performance measures and financial incentives in the face of uncertainty about the reliability of new findings; collecting data around provider compliance; distributing rewards; and defending penalties.

Now, if a Medicare pay-for-performance scheme is administered by CMS, providers will have inordinate influence over every step of that process. As do Medicare’s payment systems broadly, a pay-for-performance system would spur congressional administrative lobbying by providers who seek to protect or increase their incomes, who fear being penalized for factors beyond their control, who don’t want to change the way they practice, who want additional research funding devoted to their modes of care, who seek to gain advantages over their competitors, who wish to ensure that performance measures can be gained, who do not want the pay-for-performance system updated too frequently, and who

want only one set of performance measures set by Medicare and then adopted by private insurers.

And as much as we in this room and as much as pay-for-performance enthusiasts, and I do count myself among them, as much as we might want the pay-for-performance system in Medicare to work, even we aren't going to pay as much attention to that process as the provider does. The healthcare industry spends more money lobbying congress than any other industry. And a pay-for-performance scheme administered by CMS is only going to increase that spending.

So that I think provides perhaps the most powerful argument for diverse private experiments in pay-for-performance. The fact that private plans are not as easily influenced by providers will offset the relatively weaker market position and leaves open, I think, the question of whether private plans or Medicare would have more influence over providers' behavior. Though Medicare theoretically has the power to change providers' behavior, providers typically have the political power to change Medicare's behavior.

So, ultimately in my view, pay-for-performance schemes would be more effective if they focus on precision first and market power second. And the smaller experiments by private insurance, I think are better positioned to deliver

that precision and could build market power by establishing a reputation for quality.

Now, whenever we're talking about pay-for-performance, I think it's important that we keep in mind just where we are in the process of implementing this and figuring out whether it works. And we don't know if pay-for-performance really works. And we don't know how much it costs. And if we don't know whether it works and we don't know how much it costs, then we certainly don't know if it's worth the money that we're spending, if it's cost effective. You don't know how much it costs or if it's effective, you can't figure out whether it's cost effective.

There have been precious few randomized controlled trials of this concept. And the results of those precious few trials have been inconclusive. So, whatever enthusiasm exists for pay-for-performance is not derived from the type of evidence of effectiveness that pay-for-performance enthusiasts believe should guide clinical practice. Third party financial incentives remain an unproven tool for improving healthcare quality, let alone in a cost effective manner.

So we help policy (off mike) frequently lament providers' eagerness to use whatever new piece of technology they get their hands on, so it's a little more than ironic when we get our hands on a new policy tool and exhibit the same behavior.

So, in my view, these difficulties suggest that certain approaches would maximize the potential of pay-for-performance while minimizing any harm, particularly in Medicare. The first approach we should take is diversity. Given the many ways that provider focused pay-for-performance incentives can go wrong, I think that smaller private experiments, the kind that Meredith was describing, are preferable to a grand experiment that – a grand public experiment that crowds out all others.

The current system of pay-for-performance programs provides that type of diversity, allowing insurers and employers to conduct experiments and learn from each other's successes. And the competition to improve quality care in a cost effective manner encourages private purchasers to experiment in pay-for-performance. Private control gives them the flexibility to design and alter those experiments nimbly and as important, any harmful failures are confined to much smaller populations.

I think the politics of Medicare always guarantees that any potential harm coming from a CMS administered scheme would be more likely to occur, harm more patients, and take longer to correct. Therefore, rather than let CMS or some quasi governmental body even administer pay-for-performance system in traditional Medicare, I think Congress should consider confining pay-for-performance, at least provider focused pay-for-performance financial

incentives to Medicare advantage, under which beneficiaries can choose a private plan that covers Medicare – that provides Medicare covered services and Congress should resist the temptation to expand pay-for-performance into traditional Medicare.

Now, the second strategy I think that would maximize potential pay-for-performance while minimizing the harm is for employers and insurers to experiment not just with provider focused incentives, but also with patient focused financial incentives. Private insurers have already begun to do so.

One weakness of provider focused financial incentives is it can encourage low quality. They can create perverse incentives that encourage low quality care or reduced access to care, and they're completely opaque to the patient. The patient is not aware of those financial incentives and is not – just doesn't know about the forces that are affecting her healthcare.

In contrast, patient focused financial incentives engage the patient in the pursuit of quality while allowing patients and their doctors to deviate from what the experts consider best practices if they decide that that's in the best interest of the patient.

So, if traditional Medicare is to use financial incentives to drive quality, I'd suggest that those incentives would be better targeted to individual

patients. In either case, the ultimate locus of decision making would be better left at the level of the individual patient.

So, in sum, I'd suggest that if the potential risks of a broadly applicable pay-for-performance system are serious enough, that those adversely affected should have the right to opt out of those systems, either by making those incentives focused on the patient herself or confining pay-for-performance program to an environment where the patient can move from plan to plan. And perhaps, the patient should have the responsibility of bearing that cost for the choice to opt out of the system.

Moreover, I'd argue that pay-for-performance holds enough promise that special interests shouldn't be allowed to stymie its development through political pressure. Thank you.

(Applause)

MR. HELLMAN: This panel will be – I'm trying to limit this one just to discussions on pay-for-performance and then we'll go onto the second speakers and their discussions.

Are there questions? Yes?

MR. KELLEY: All right. Bruce Kelley with the Mayo Clinic. Michael, I wanted to ask you your thoughts on this. On the previous panel, one of the speakers mentioned that you'll never get really good transparency and quality

and cost saving until the patients are paying more of the bills themselves, if I can paraphrase.

You talked about Medicare and the idea of a patient – you pay-for-performance based on that the patients are involved in or the consumer as opposed to the provider.

What do you think of the idea that Medicare, it has a piece schedule, say okay, Medicare will pay what it will pay, but the provider, the physician can charge more or less and let the patients have some say then in did I get good quality care; is this worth it?

Interestingly, both of those are currently against the law.

MR. CANNON: It's an interesting question. I was at a Cato Institute event that we had on pay-for-performance and someone brought that very idea up to me after the event. And that very person is actually sitting in the audience here as well. Yes, it's illegal to balance bill, but that's one option to, you know, for allowing – for Medicare to encourage higher quality healthcare. I mean if you were to release that constraint, that's one option for doing so.

(Off record comments)

MR. HELLMAN: Other comments? Greg, did you have a comment?

MR. CANNON: And Peter was the one who brought it up. I don't know if you wanted to weigh in on this, Peter.

MR. HELLMAN: Go to Peter.

MR. CANNON: I have to confess. Peter sent me a document about this, and I have not read it yet, so that's why I want to defer to you.

MR. MCMANIMON: Hi. I'm Peter McManimon with Blues(?), Hale, and Hamilton right now. The actual McManimon modest proposal would be as follows: that you would have HHS or CMS designate a series of standards and a level of performance above which would qualify a physician to be high quality or some star or whatever.

Physicians who had voluntarily met those standards, and that might include providing information from their non-Medicare patients in terms of their aggregate performance, but if they volunteered that, and they could demonstrate that they were in excess – they exceeded the standards, they have the authority to balance bill under Medicare, not that they would be required to, but that they could balance bill.

And we know from Ed Pack(?) that private fees are 20 and even 30 percent higher than Medicare, so that we'd be talking about real money potentially. In theory, it would not cost the government anymore because the Medicare allowance would stay the same. But we would also find out what the

patients thought this high quality was worth. And because it would be voluntary on the part of the physicians, if they didn't want to participate, they didn't have to. If they wanted to, and I suspect a lot of them would, we get a lot more information available about individual performance, and we'd probably get an improvement in performance. So that's –

MR. CANNON: And I think – just to follow up on that, I think that, you know, if we're – what we're doing is liberalizing the pricing structure within Medicare, that's something that I would certainly be sympathetic to.

My concern about it is that you suggested that if the physicians meet these quality criteria. My concern is about how the quality criteria are set. One way to get around the problem so that it's not Medicare who is setting those quality criteria is to have, you know, a list that CMS comes up with of private organizations whose criteria would qualify – compliance with whose criteria would qualify a physician to be able to balance bill.

It's just one way of detaching that – the quality questions from the political process.

MR. HELLMAN: Greg, did you have a comment?

MR. GREG: A question mainly for Meredith, although I'd be interested in all your thoughts about this. You were less than enthusiastic about the prospect of consumers getting mobilized to support pay-for-performance and

unenthusiastic, therefore, I take it about the prospect that employers would carowit(?) absent the promise of savings as well as quality.

Could you say some more about that, and is there any hope given the movement towards more data to be available to consumers, that maybe we would see a wave of interest, even though consumers aren't footing much of bill, a wave of interest on the part of consumers in pay-for-performance?

MS. ROSENTHAL: Did I mention consumers? Maybe my lack of mentioning them was demonstrating my lack of enthusiasm.

MR. GREG: When you mentioned employers in one of your slides, you focused on their not being interested unless there's a cost.

MS. ROSENTHAL: I think with regard to employers, clearly they care about the welfare of their employees for a variety of reasons, you know, largely those labor market reasons that we think they offer health benefits for in the first place. And so they care about delivering a quality benefit that's valued by their employees. But, clearly, the cost trends are at the fore of their interest at the moment.

With regard to consumers interests in quality, I think, you know, I think this proposal also is very provocative. For me, my concern is with regard to historical patterns of consumer choice. They don't seem to relate to quality information, and so – and I'm optimistic that that's evolving reality, that, you

know, consumers over the last decade, if you look at the research for I think fairly meaningful quality measures that have been disseminated, consumers have not been taken up, have not been used by consumers.

But there's a lot of education going on and I think a lot of novelty right now with regard to delivering that information in a way that's more meaningful to the way people actually make decisions.

But I see – I guess as Karen said earlier, I see a role for consumers for sure in promoting quality and in guiding the system towards what they really want. But I'm very cognizant of the real information problems and decision making problems that consumers face.

And I'd say we're not really there. I'd put a much greater emphasis on supply side incentives than demand side. Well, really looking at both. But I think the more promising opportunities for health system change are not about market competition but really about a revised payment system that gives the providers incentives to reorganize and develop the kinds of innovative ways of delivering care that we were talking about earlier today.

But I don't see that consumers have no role to play, just I think diminished relative to these other strategies at the moment.

MR. HELLMAN: Bob?

MR. BOB: (off mike) with hospitals and doctors, we take on pay-for-performance contracts where about half of the incentive money is about efficiency, admissions, radiology use, pharmacy. But for the more fragmented world out there, the onesies and twosie doctors, are there any pay-for-performance models that seem to offer some potential for, you know, directly related to efficiency?

MS. ROSENTHAL: In those PPO programs, there are plenty that look at imaging and generic substitution. I don't know of any that have successfully looked at global measures of efficiency. And you can imagine the kinds of adjustments that you'd want to do to any global cost per episode measures would be tricky on the small population.

But I believe that's what care focused purchasing is really about and that I would expect some of the payers -- care focused purchasing, it's an aggregation of payer data, national payers for the most part to try to get large sample sizes for measuring efficiency at the individual doc level.

MS. THOMAS: I'm Dana Thomas. I'm with the US Coast Guard. I had a question. I guess I'm thinking about as an economist, can you tie back instead of like the pay-for-performance idea just to the healthcare outcomes, the quality of the outcomes, and the cost to something more tangible for the employers, like the health productivity measurements, the decrease in disability

costs or absenteeism or even presenteeism(?) in their work force, and you know, be able to judge the quality programs or the care that they're getting on those metrics? I mean does that seem feasible or realistic?

MS. ROSENTHAL: It certainly is a hot question. And I know there are some studies looking at that. It's measuring presenteeism, as you can imagine, is very tricky. And so the studies that I know of have been done actually in large health plans where they actually measured how many claims were processed. So you had – not that many of us work in places where our productivity is easy measured, except for maybe junior faculty.

But I think that's – I wouldn't be as narrow as that. I do think that's important and I think employers are open to those kinds of arguments. But I think that it's also just as important how much their employees value the product they're getting in a health benefit, because that's part of – again, that's part of attracting labor.

So, it's not totally – they're not trying to minimize their health benefit cost. They're just trying to maximize the value of that.

MR. HELLMAN: Just as a segue into the next section, the last comment, Bob, and then we'll move on to the next group.

MR. BOB: This relates to Peter's (off mike). I was the co-chair of the Institute of Medicine sub-committee that served the larger committee on pay-

for-performance. And we discussed and kicked the tires of various incentive mechanisms directed both at providers and at beneficiaries. And you know, we respected your idea. It's political legs, I would think, are very, very short, you know, because you will be accused of denying access to low income beneficiaries.

The alternative, of course, is to say that we will reduce the coinsurance fraction for Part B services and the deductible for hospitals to those beneficiaries who select high quality or efficient providers. The downside to that, of course, that could cost you a whole lot of money.

MR. CANNON: The other downside is who is going to be selecting those high quality providers.

MALE SPEAKER: Well, you have that problem with all of us, so.

MR CANNON: No, no, no, no. But is it going to be disproportionately the low income people? I mean there's a – Peter will get attacked for his idea because – for cutting off care to low income people. But, all of these pay-for-performance ideas have that potential including that one. Because are the high quality providers going to locate themselves where the low income people live?

So –

MALE SPEAKER: I think we could get into that.

MR. HELLMAN: I think maybe we'll stop this session, and we can round back on some unanswered questions after the last part. Thank you both very much.

(Applause)

MR. HELLMAN: I'll do this from here before I unhook myself. I'm turning around so I can unwind. I had a different kind of unwinding in mind, but anyway our next two speakers are Catherine Baker. She serves as a member of the Council of Economic Advisors. She received her BA in economics from Yale and her PhD in economics from Harvard. She's an associate professor of public policy at UCLA and a research associate at the National Bureau of Economic Research.

Wait, wait, Catherine. I want to do Bob. Unless you want to do Bob.

I think Bob is – Bob Reischauer is well-known to all of us. He is the president of the Urban Institute, has served as director of the CBL, the Congressional Budget Office, and to those of us here, a long standing and former member, a very distinguished one of the Brookings. And any device to get him back is well worth the effort.

So, I'm especially pleased to have him here. He has his undergraduate degree from Harvard and his PhD from Columbia.

Now.

MS. BAKER: Okay. Can we maybe dim the lights a little? Great. Excellent. Thank you all for sticking around, and as the next to last speaker, I will try to just speculate wildly and move around a lot and keep everybody awake.

So, the goal I think of a lot of this discussion is to think about moving towards that higher quality care and the role of patients and the role of providers. And what I'd like to talk about now is the role that as policymakers we can play in giving a nudge towards higher value, higher quality care.

And there are a number of policy instruments at our disposal, and none of them is easy and none of them is obviously beneficial. And some of them are obviously harmful and hopefully we can discard those. But I'd like to lay out for you some options that I think are promising.

I don't think that I need to spend anytime convincing the people here that healthcare spending is growing rapidly and that that's potentially a big and bigger and bigger problem. On the public – you know, totally we're spending about 16 percent of our national dollars on healthcare. And that's growing on both the public side and on the private side.

And on the public side, entitlement programs like Medicaid and Medicare are rapidly consuming the entirety of the federal budget. And if nothing were done, we would spend more on Medicaid, Medicare, and social security than

we spend on everything right now. And that means we either need to double taxes or quit all the other programs that you're spending on or do something to reign in spending on those programs.

And we talk about that in the long run. You've heard a lot about the unfunded liability of those programs, but they impose real constraints on public spending now. They're already crowding out a lot of discretionary spending. So this is surely a problem for the long run, and I would argue a big problem even today.

On the private side, health insurance premiums are growing three times as quickly as CPI or as inflation and that means that workers are taking more and more of their compensation in the form of healthcare. Now, both of those things would not be such a problem if we really thought we were getting out money's worth out of the system. We don't sit around bemoaning the fact that we're spending more and more and more of our national dollar on you know, consumer electronics or something that wasn't around before to spend any money on. And there's a lot of great new stuff in medicine that we're spending money on. So, why are we so worried?

Well, you've heard a lot of evidence today and in the long run that we're not getting out money's worth. And so, when you're spending an increasing share of your resources on something that is of questionable value on

the margin, that's something that you want to pay attention to right away. But I think that's a pretty easy sales pitch.

One thing that people may not realize though, is that a big chunk of the dollars we spend on healthcare out of public budgets are going to subsidized private care through the tax code. Employer provided insurance is untaxed, and that means that we spend money by not collecting revenues on that worker compensation that we would be collecting if that employer provided health insurance didn't have tax favored status.

Now, that sounds like some obscure part of the tax code, but really we spend as much money on that as the federal government as we do on Medicaid. So it's a big chunk of public spending, and it's going to be of increasing importance as private health expenditures rise.

So, can our spending go further? Are we just stuck in this box where we have low value spending and there's nothing to do about it? We spend more than twice as much per capita as many developed countries. There's evidence internationally that we spend a lot of money. There's evidence that we don't necessarily get our money's worth because our health outcomes are certainly not twice as good as those other countries. And even within the US, there's evidence that we are not allocating our dollars efficiently.

And I know I've worked with Elliott on some of these issues, and I'm sure you've heard a lot about them before, so I'm going to zip through this. We spend a lot of GDP on healthcare. Our outcomes don't look that great. Even in the US in areas where we spend more on Medicare, we get lower quality care, not higher quality care. So all of that is to say our healthcare dollars should surely be able to go further.

So, what are the consequences of that inefficient spending that I have just zipped through and hopefully didn't have to convince you of. Healthcare dollars aren't going to the places with the highest value. When we're spending so much more money in some parts of the country without commensurately better outcomes, that tells you that you could move some money around and do better for your dollars.

Not only are we not spending our healthcare dollars as wisely as we could, we're not allocating our resources as a country correctly between health and other goods. So, it could very well be that people would like to take some of that lower value use healthcare dollar and put it towards rent or clothing or something else. So, we're not allocating efficiently within healthcare. We're not allocating efficiently between healthcare and other goods.

And all of that has real implications for how well people are doing, particularly at the low end of the income distribution and ultimately, for standards

of living for everybody if it affects economic growth. So, our goals should be to get higher value care, to have our dollars go further and have spending decisions based on somebody somewhere evaluating whether the cost of a procedure is warranted by the benefits that come from it.

And if we could get that kind of allocation of resources, we could stop worrying about how much we spend on healthcare. We'd be getting our money's worth. You wouldn't worry about what fraction of GDP it was consuming nearly as much.

Now, that goes along with, I think, having care more widely available and affordable. Part of the reason that we have a rising rank of the uninsured is that healthcare is increasingly expensive for people who don't have health insurance, especially for people who don't have health insurance through their employer. Because the non-group market in health insurance does not function well now. So our policies need to take that functioning into account.

So, to understand how you can push us in that direction, you need to understand why healthcare spending has grown so much recently. And it's not that we're going to the doctor so much more often or that we're going to the hospital more often, or even that we're staying at the hospital longer once we go there. The real source of increase in healthcare spending is the intensive

technology that gets used once you go to see the doctor or once you go to the hospital.

Now, on average, that's great stuff. The healthcare advances that we've seen in the last 40 years have extended life expectancy remarkably. They've improved the quality of life. They've improved mortality post heart attack. They've improved infant mortality. They've improved lots of different measures of healthcare, and nobody would advocate going back to 1960's medicine at 1960's prices.

But that said, on the margin, we're not doing so well. The last MRI that you do, the last angioplasty, that has very little value to that patient, even though the technology as a whole is well worth what we're spending on it as a whole. And that's because consumers aren't in a position to really evaluate if this is worth it for me.

Certainly, Medicare is not doing that very well. We're not doing it well on the private side either. The barriers through Medicare, I'm not going to spend much time talking about, mostly because I want to wrap up in my allotted time and also because you've heard a little bit more about that.

On the private side, the tax treatment that I mentioned before creates a very unlevel playing field. You get a tax advantage if you get your

insurance through your employer, but you don't get a tax advantage if you buy your insurance on your own or if you pay for routine care out of pocket.

Now, again, this sounds minor, but it's not. You're talking about a 30 or 40 percent sale on services that you consume through your employer provided plan relative to services that you consume in any other way, either through insurance that you buy on your own or through out of pocket spending.

So what this means is that people who choose a bare bones policy or a basic health insurance policy and pay for routine care or low cost care out of pocket face a severe tax penalty, payroll tax and income tax, 30, 40, even 50 percent.

So this means that there's a strong incentive to get a really generous employer plan that covers everything. Now, if our auto insurance or our homeowners insurance looked like this, you would have, you know, free detailing on your car every six months, somebody would be shampooing your rugs covered by your insurance. That's not the way we purchase any other kind of insurance because it doesn't make sense to ensure against routine expenses that you can afford.

Insurance is for catastrophic expenditures, for unexpected things. Insurance reduces uncertainty and provides crucial financial protection against high expenses. That's why we all have deductibles on our auto policy and on our

homeowners' policy. And for health insurance, clearly health is different from other goods, but what isn't different is that it doesn't really make sense to insure routine care that you can afford out of pocket. Because insurance has its own costs. Insurance is expensive.

So this structure that we've set up that is, you know, an historical relic, pushes people into these really expensive first dollar cover plans, which means they don't consume care efficiently once they're in them, and it means that health insurance for people who don't have it through their employer can be prohibitively expensive.

So how do we improve those incentives? We can remove the bias against basic plans and consuming routine care out of pocket. You can do that in two different ways. You could level the playing field up. You could have all health expenses be tax free, whether you get them out of pocket, whether you get them through your insurance, no matter where you get your insurance.

You could level them down. You could have all health expenses taxed the way any other type of income or compensation is taxed no matter where you get your care. Either way would remove the bias that pushes people into expensive first dollar coverage, but they have different implications for how much healthcare people consume overall and how expensive health is relative to other goods.

So I would like to lay out a path that builds on the success of health savings accounts. Now, people are pretty familiar with health savings accounts and I won't go through a lot of the details on that. The basic premise is that if you buy a catastrophic plan that has a deductible of about \$1,000 per person, \$2100 for a family, you can then create an account to pay for your routine care out of pocket with tax free dollars instead of having to pay taxes on that routine care.

So it eliminates the bias against that kind of policy that was otherwise in the tax code. These have been increasingly popular. When they were first offered in 2004, obviously they were very new. People weren't sure how well they were going to work. There are now more than three million people enrolled and that number is rising quite rapidly.

I won't go through the current rules. So the advantage of this is that – the main one is that the tax penalty is removed, which I just described, but it creates the incentive then for higher value care consumption because people are making decisions about their healthcare, trading off the value of that dollar of getting healthcare against the dollar of consumption of anything else that they might do in the future.

And health – HSAs have an advantage over making all healthcare spending tax advantage, because if you can bequeath this to you descendants or

you can use it for non-health expenditures once you're over 65, the incentives to really evaluate how you want to use those resources are preserved. It makes the policies that go along with the HSAs, the high deductible policies, much more affordable for people, and it can be combined with other proposals to expand access.

So, I'm not going to belabor that because I think right away some issues come to mind about whether this is fair. Is this just for the healthy and wealthy? Is this really going to bring down expenditures? There are some real questions to ask about this, so I'd like to spend my last negative five minutes talking about the effect on overall spending, afford ability, and risk pooling issues that I think everybody rightly questions.

So, first of all, I would argue that HSAs could be a really valuable tool in reigning in health spending. So the first reason I think that people think this isn't particular – this might not work is that it still offers important financial protection. There's a deductible, but then there's an out of pocket max for most plans of around \$5,000. We all know that most health expenditures are done by people way out in the tail of the distribution. So 80 percent of healthcare dollars are spent by the 20 percent of people who have the highest spending.

What would a high deductible policy like this do for their spending? Well, if you back it out, it turns out a fair amount of spending would

be tentative in this plan, because the first \$2,000 for a family say is the deductible. The next \$2,000 that families pay out of pocket is paid at a coinsurance rate of about 20 percent for the average HSA. So that means that up to \$12,000 of medical spending would be subject to some cost sharing, higher cost sharing than people currently pay.

So if you do a back of the envelope calculation, about 50 percent of health dollars are spent by people with less than \$12,000 a year of bills. So that does leave a chunk of spending that wouldn't be touched by this. But it leaves half of spending where people would face increased incentives to be cost conscious consumers. And if you back out roughly how much of this would translate into reduced expenditures? If you went – if you took the entire population and rolled it from current PPO plans into a typical or average HSA plan, it would reduce spending by about five percent.

Now some people will see that as, you know, the glass is five percent empty. That sounds like a lot of money to me, five percent of sixteen percent of GDP is a lot of money. So that's a good thing.

Now, the second criticism is wait a minute, how can people make a decision about what kind of healthcare to consume in an emergency situation. Most healthcare is on these expensive procedures, you're really expecting

somebody in a crisis to make a decision about what kind of healthcare to consume. Answer: yeah, they do it all the time.

First of all, only about 20 percent of healthcare dollars are spent in emergency situations. That doesn't mean they aren't spent on very sick people. But if you define an emergency as any time you have an injury, any time you go to the emergency room, anytime you receive care within the first 24 hours of a critical episode, and you sort of add up all those things, that's about 20 percent of dollars.

So most of the really expensive stuff is happening, you know, days later when decisions have been made about treatment patterns. And so people have time to evaluate where am I going to get the highest value care, not where am I going to get the most care, not where am I going to get the cheapest care, but where am I going to get the care of the highest value to me. So there's plenty of time for that.

And there's evidence from the medical literature that when people have improved information about quality, they go to higher quality places, even in emergency situations. So it's not that people aren't able to evaluate the choices available to them; it's that often they don't have any reason to do so and often they don't have any information about prices.

And I know people have talked about that already, but certainly all of this is predicated on the idea that people need information about quality and they need information about price. And the federal government can play a strong role in leadership there.

The last point that I want to make on this and then I will zip on is that people still get the negotiated discount rates that their insurer provides. So I think that in this world of higher deductible health policies, people have in mind you're out on your own. You know, how are you supposed to get as good a deal as Etna got when you go to negotiate with your provider?

You still get Etna's rates because you're still covered by a high deductible health policy, and that health insurer who's providing that policy still has an incentive for you to save money, because they're on the hook for anything you spend upon your out of pocket max. So people are still getting all of those advantages, but now they're getting more.

There is evidence that in fact people are moving towards more cost effective use of care. I give the example of the use of generic drugs, but these are still very new plans. For the long run, evidence is not in yet. And I'll move on.

Last, are these just for the wealthy? Is it something that poor people can't afford? Well, what people don't always take into account when they evaluate the effect of this higher deductible on a low income family is the fact that

the premium is so much lower for these policies. It's lower both because people are paying more of the up-front cost themselves, but also because their improvement in behavior as the change of incentives is taken into account and the policies are more – the care provided through the policies is more cost effective, so the premium can be even lower.

So, if you look at the data on this, you see that the average premium is almost – takes up almost two thirds of the difference between the difference in the deductibles. So this means if your deductible is \$3,000 more, your premium is \$2,000 less.

So, if you hit your deductible year after year after year, you might be worse off in the HSA than you would be in a traditional policy. But if you don't hit your deductible year after year after year, you save money in these policies. Because you take the money from the premium, you put it into your HSA, and then you use it to cover any out of pocket expenses you have.

Now, what about the chronically ill, who hit their deductible every year, every year, every year and always have high expenses? Fundamentally, any insurance plan that we devise is not going to be able to take care of a chronically ill uninsured person who is trying to get insurance, because that's not an insurable event.

If you are chronically ill and you have \$10,000 of spending year after year after year, an actuarially fair policy will charge you \$10,000 for that care. Because insurance is about uncertainty. Insurance is about pooling risk and protecting against the unknown. A chronically ill person who isn't already insured based on a healthy health status to begin with can't get insurance. It doesn't incorporate that known fixed expense. And if we want to help those people, we need to design policies to give -- first of all, get everybody insured when they're healthy. Second, during the transition when some people who are uninsured now and have chronic illnesses can't get insurance that they can afford, give them extra money. But don't design the insurance system to cover those people because it's not insurance. Just call it a transfer to low income sick people and transfer money to them that way.

So I'm going to stop there. I think there are plenty of other concerns, all of this predicated on better information being available that you've heard more about. But ideally, with that better information and with a critical mass of cost conscious consumers, people will help drive the market towards higher value care while maintaining the important financial protections that insurance provides. Thanks.

MR. RISHOUER: Let me say how much I appreciate being given the much coveted last speaker of the day slot on a conference that is on Friday. I mean it's really a three for. You know, you can't.

Cognizant of the limited amount of time that we have and the richness of the presentations that have gone before, I'm not going to give you a rich dessert, but rather some comments on the discussion that my fellow panelists have introduced in some of the earlier discussion this morning.

You know, for the past decade or so, we've really seen an explosion of efforts that are designed to develop mechanisms that we all hope are going to shrink this gap between the practice and the potential of medicine in the country.

We've seen efforts to encourage the spread of IT. You've heard about them, electronic medical records, computerized physician order entry systems, bar coding of hospital supplies, electronic transmission of lab results and diagnostic tests, electronic patient monitoring both in hospitals and when patients are at home.

We've begun to develop and publicly make available performance measures for various types of providers. It started with heatus measures for HMOs, but it's expanded as Mark told you through acute care hospitals, home health agencies, sniffs(?), various types of physicians.

And as Meredith has elaborated on, some plans have even begun differentiating provider payments based on performance. But the overall amount of this relative to how much we pay to providers is pretty minuscule at this point.

There's also been a lot of efforts more recently to measure effectiveness, comparative effectiveness, and even cost effectiveness of certain drugs, devices, and procedures. But I can't say a lot of this evidence that we have gathered has played an important role in coverage decisions or un-coverage decisions, which is what it should be playing a role in.

And we've begun encouraging a lot of strategies to manage chronic care and to manage certain diseases. In theory, all of these efforts should work to close the gap that this conference is focusing on, but in practice, as several of the speakers have mentioned, the jury is really out. We don't know how effective this is going to be.

My own feeling is that all of these efforts, even under the best of circumstances are likely to produce only a very modest narrowing of the gap between practice and potential unless we're also willing to undertake additional steps to spur some very fundamental changes in the structure of the healthcare delivery system and the ways we choose to finance all our healthcare in the discretion that we leave in the hands of both beneficiaries and providers and in the extent to which we cover the uninsured.

And such changes can come about through wrenching reforms of the sort that were proposed in the Clinton Administration or in more evolutionary ways. We've tried both and I think the bottom line is neither has succeeded at this point. But hope springs eternal and the magnitude of the problem means we will revisit it over and over again until we get the right outcome.

From what you've already heard, it's obvious that the structure of the healthcare delivery system has to change if we're going to develop a system that produces high quality care in an efficient way using resources parsimoniously. The current system, as you've heard over and over again is siloed, fragmented, uncoordinated, duplicative, and inefficient.

We all know that producing high quality healthcare is a team effort team sport, not an individual sport, one in which there has to be an accountable party that in concert with the individual patient defines appropriate care and that care should be defined across a lifetime, not a year; organizes that care; allocates resources for the most appropriate providers; educates and encourages the patient to shoulder his or her responsibilities for good care; and monitors the results.

In short, you know, healthcare is a lot like a football team. You need a general manager, a coach, a quarterback, journeyman players, scouts, and others. But what we have is a bunch of individual players, each wanting to be the

quarterback running around the field, which doesn't have defined borders or a common play book or a common set of signals, and we pay them for doing it.

To mix the metaphor even more, we have patients who want to graze freely on the open range consuming as much or as little as they want wherever they choose to wander on the commons. We tried to limit this in the 1990's, and there was a backlash. And now we're probably back where we were in the late 1980's.

We have providers who want the freedom to organize themselves and build institutions without regard to any rules or zoning regulations. We equally support solo practitioners, small groups, and multi-specialty groups. Dr. Lee suggested that small groups, and I think he's correct, can never have the inherent capabilities of doing what has to be done to ensure high quality integrated care.

And at some point, we have to say no, but nobody has had the guts to do it because of the likely consumer backlash here. And so the consumer backlash has affected both our attempt to limit what the patient has in the way of options and with respect to providers as well.

We've allowed a proliferation of institutions, be they specialty hospitals, rehab and long term care facilities, ASCs, imaging centers, et cetera, et cetera to further fragment care and encourage overutilization. And many of these

largely exist because of distortions in our payment systems, which they're designed to exploit.

And all of this persists year after year in large measure because of our financing and payment systems, which at best support this inefficiency and at worst strengthen and reinforces it. In short, we don't have our financial incentives aligned to encourage the behaviors that will improve quality, encourage efficiency, and slow the rate of cost growth.

We pay for quantity, not quality or what we should pay for with, ideally, which is health outcomes. We have a very distorted payment system. We saw one example of it and the question or the anecdote about the dermatological services that the doctor received and a price that was charged for that.

And those of you who are in the Medicare world know this full well, but we devote totally inadequate amounts of resources to calculating and updating and changing the relative payments that are made to various types of providers for various services that they provide. And some people say well, it's Medicare and it's screwed up, but one has to realize that this payment structure is relied upon by many, many private insurers when they set their relative payment rates as well. So this is a serious issue.

The other members of the panel discussed two of the silver bullets du jour for changing these incentives that we have. Pay-for-performance is

focused on improving the supply side, providing payment incentives that are going to encourage providers to improve quality and moderate cost growth.

Steve Shortell and Elliott Fisher and I served on this Institute of Medicine Panel, which in September issued a pay-for-performance report that recommended that – sorry, Michael – that pay-for-performance be phased in for the Medicare program. And I’m also the vice chair of the Medicare Payment Advisory Commission, which for the past several years has recommended a similar policy change. While I do think that some deliberate but modest steps in this direction would be beneficial, my immersion in this topic over the past couple of years has left me with an appreciation for the overwhelming complexity that’s going to be involved in getting it right because of the fragmented nature of our delivery system. In short, I share a lot of Michael’s hesitation about this and even Meredith’s concerns about going too fast too soon.

The development of a robust set of accurate and timely performance measures is really a huge challenge. Scaling and combining individual measures into a composite index, the providers will find fair, understandable, and actionable raises numerous methodological issues.

You can think of, you know, all these individual measures we have. You know, were you given an aspirin when you entered the hospital after a heart attack? You have that. Were you given a beta blocker when you left?

What's the excess mortality rate in that hospital? Do you add those up just like that?

I mean certainly some of them must be a little more important than others. And then you think about how you would actually do this, and we could have NASA devote 10 years to this, and it still probably wouldn't be satisfactory.

Both the ION panel and Medpac(?) believe that pay-for-performance should reflect the shared accountability for medical care so we don't find ourselves strengthening the silos. But with few exceptions, our fragmented system doesn't provide easier or acceptable ways of doing this. Who do you give the performance bonus to, if you think about this, when the care has been provided by primary care doctor, four specialists, a hospital, a home health agency all working together to produce the result?

You get Elliott and others who are working on innovative arrangements to overcome this and you have some integrated health systems in the Boston area, the Mayo Clinic, Isinger(?) and places like that where you might find an answer to this, but in the vast swath of this country, there isn't an obvious place where these resources could go in a pay-for-performance system. And so, they'll have to be some wrenching adjustments or very unequal distribution of pay-for-performance bonuses if you were to go forward.

And then there are the problems that arise from the need to reward not just clinical quality or patient satisfaction, but also efficiency for which we have very few, if any, robust measures. If efficiency is not part of the game plan, we're going to find that we might improve quality, but we're going to push up costs a whole lot.

The standard approach to examining efficiency is to look at resource utilization across episodes of care. And you define episodes such as the year after a specific diagnosis or the two weeks before a hospitalization and the six months after a hospitalization and all of the care that is within that area that relates to the diagnosis.

Medpac has done some pioneering work in this area that illustrates how complex it's going to be to provide accurate and effective efficiency measures. Some of this group and this work grew out of a rather surprising finding last year, which was Medpac's staff produced a table that showed that for a number of diagnoses, coronary artery disease for one, the resource intensity of episodes of care for CAD in Minneapolis was significantly higher than it was in Miami. And this went against all of our common knowledge that Miami is very inefficient place and Minneapolis is one of the more efficient.

This is measuring resource use by standardized dollars for procedures, so there's no – and there's some risk adjustment involved in this as

well. Well, the Medpac staff drilled down a little further into this and it found surprisingly enough that for the average CAD diagnosis in Minneapolis, they used more high cost stuff, like hospitalizations, than they did in Miami.

So then they drilled down to the next layer and what did they find? They found that the fraction of the Medicare population in Miami with a CAD diagnosis was 23 percent. And in Minneapolis, it was only nine percent. And so, then we looked at the two types here, the diagnosis only people and those who got some kind of treatment. And you found that folks who got treatment actually in Minneapolis received 12 percent more resources than those who received treatment in Miami. But for the diagnosis only group, the ones that came in and were diagnosed but didn't do any significant treatment, it was twice as expensive in Miami as it was in Minneapolis.

By now, you're supposed to be confused. That's the purpose of what I'm doing. But it gets down to how difficult it's going to be, because you have to come up with some notion for particular conditions what's the right acceptable level in different geographic regions or for different patient populations. And unless you can do this in a sensible kind of way, pay-for-performance is not going to lead you down the path we all hope that it will.

Kate's presentation focused on the demand side of the equation, ways in which patients might be incentive-ized to become more cost conscious

and more informed consumers of healthcare. And she's an advocate of catastrophic health plans and health savings accounts and changing in the way we treat health expenditures in the tax system.

I have a lot of reservations about this, and I'm not going to go through them in detail, so we'll have some time for Q's and A's. But I'll just tickle off what concerns me most. First, I think like the managed care revolution of the early 1990's, I have the feeling that the make the consumer king movement has the cart before the horse in the sense that she's willing to admit that we don't really have as much information and knowledge as one needs to make the system work.

And so, you run the risk of creating a new system which people then frustrated with and we have a backlash as we did in the late 1990's, where consumers said, you know, you gave me managed care and they just stunted on the care I had and didn't give me any kind of information that I was getting higher quality care. And in many cases, of course, they weren't, but – which was why they didn't get the information. But there was no attempt to gather that information before.

Second, even for something as vital as healthcare, I think there's a sizable portion of the population that can't or may not want to shoulder this much

responsibility for decision making. They don't want to invest the time, the effort to make sensible choices.

If we look around at the way people consume or invest in other very important issues, you know, how they treat their retirement savings, the purchase of a home or a car, decisions about mortgages, how they treat credit cards, how they choose spouses, you know, it is clear that you know, a high fraction of the population is not the rational consumer that the economists, analysts, lawyers would like to see everywhere. And I think we have to reflect that in the way we design our healthcare options.

Third, I fear that the approach that's being advocated here could easily strengthen the fragmentation of our delivery system. Most, I think, Americans like that aspect, the fragmentation. They don't realize the down side of it. And if they're in this free range environment as individuals, they're going to fight hard to keep it that way.

Fourth, I think there's a danger that quality of care over a lifetime could be jeopardized by the myopic nature of consumers who may be incentivized to invest less in care when they're young than they should for an optimal healthcare situation over their lifetime.

Fifth, I think that structures like the one Kate describes could prove to be unacceptably inequitable unless contribution limits to HSAs, premiums,

deductibles, or coinsurance amounts are varied with income and with health risks and unless the tax deduction has transformed into a credit. And I know she would agree to some of these things, but they aren't there now. And given that they aren't there now, I don't think we should get on the horse to ride.

Sixth and finally, I worry that overall expenditures related to health could rise. And I say this not because health expenditures narrowly defined will rise, but the amount that we devote to it. And I had this -- you know, everybody gets to tell one anecdote.

And I had the decision making process of was I going to offer high deductible savings account plan in the Urban Institute. And I brought my research assistant in and we discussed what our behavior would be. And of course, he would sign up for it and he would, you know -- I would make my deposit to his health savings account, and he'd be healthy as a horse for the two years before he went off to graduate school. And he would say goodbye to me, take the money, pay the 10 percent penalty, tax penalty, and go to Europe, or pay his graduate school tuition at Princeton.

And it wouldn't show up in the health accounts. Gabe would come to me and say see, we've saved. But it would show up in the entertainment account of young people. And I, as an employer, am not sure that's where I want the dollars that the Urban Institute spends, thinks it spends on healthcare to go,

especially when by making the choice he did, the premiums that I would have to charge myself, who would stay in the other option, would be higher. Thank you.

(Applause)

MR. HELLMAN: I know time is late, but we'll take just a few questions for Kate and Bob and try to stop at – as close to 5:00 as possible.

Right over there?

MR. LONDON: Yes. I'm Paul London. I asked a question earlier. I think the key to this is still the information systems. I mean I've thought for 8 or 9 or 10 years and I think the Institute of Medicine has thought since 1991 that we needed at least information systems so we could look at, you know, doctors weren't handling these little notes.

That being said, I think people, whole, want to restructure medicine, and they don't look at an industry like trucking. I mean trucking in 1980 was significantly restructured. And the government didn't think of everything that had to be done to do this restructuring. It opened up the market to a certain amount of competition. It set standards for safety, and it sort of let a lot of other things so.

And I think that, you know, the same thing happens – and companies come and go. MCI came into the telecommunications area and looked

like it was going to eat up AT&T and then it sort of disappears. You know, these kinds of things happen in other parts of the economy.

I think it's awfully ambitious to think that you can actually sort of think some plan up ahead of time that will restructure healthcare. I think you sort of got to figure out a few things that you ought to do, and I think medical records are way up there and that people ought to require this. As Newt Gingrich says, Make them do it. And just make all the doctors do it, and if they – you know, they all have computers in their offices. They use them to follow their stock. I mean, this is not some huge expense.

So, you know, I think you do that and then you don't try to restructure everything else. You see what falls out. Otherwise, it's such a daunting challenge.

MR. HELLMAN: Do either of you have a comment?

MS. BAKER: I'll make two responses. First, I think it's an important point you're raising that you can't just overhaul the whole system and start over. I think if any of us were designing a national system for delivering healthcare, we would end up with nothing like what we have now.

If we got to start over, that would be great. But we don't get to start over. We're stuck with this employer system for private health insurance,

and that's where a lot of risk pooling takes place. We're stuck with this vulcanized set of overlapping programs.

We have to think about reforms that will not disrupt a lot of the important functions of the market, and that's why some of the incremental approaches that people are talking about, I think, are great steps in the right direction that we can't pretend are the magic bullet to fix everything. But I'd be pretty afraid of the magic bullet because it comes at you really fast. So, I'm glad to start with some incremental approaches.

And in terms of picking low hanging fruit, information technology seems like a really important place to start. And the federal government buys a lot of healthcare, both through programs like Medicare and Medicaid, but also just through the federal employee's health benefit program. There's a million enrollees. Well, that's a place where you could demand better information be available.

And if the federal government starts with that leadership role and has done under (off mike), through Medicare and continuing on, and with the recent executive order promoting health IT, that's a way to use both the bully pulpit and the buying power of the federal government to get the ball rolling on standards for information, so that people don't have to guess about the way that

information is going to be uniformly collected and used both to generate quality measures and also just to generate better electronic medical records.

MR. HELLMAN: Bob, did you have any comments?

MR. RISHOUER: Yeah. The government never paid for 50 percent of trucking, so I think in the end, the nature of the product really is quite different. And the question here is if Dr. Lee and his group can provide high quality care more efficiently and a lot cheaper than an uncoordinated group of providers in the Boston area can, shouldn't we, as the person that's paying 50 percent of the total bill, you know, steer our patients towards that as opposed to what we have generally done, which is say well, you know, that kind of provider needs to be the other kind, needs to be kept in business and provide stronger incentives.

And I don't – I'm not a bomb thrower or a radical. I don't disagree with what Kate said, I mean, but I think we want to move very slowly and in the ways that seem to be the most efficacious for getting this – a more integrated system going.

MR. HELLMAN: It's 3:57, and the last word goes to Henry Aaron.

MR. AARON: Well, thanks to everybody who has presented and stayed through the afternoon session. I have – I would like to recall the speakers

to the presentations that were made in the morning. I don't think that Tom or Dennis were talking primarily about issues of access.

And I don't believe on balance they were talking primarily about issues of cost. They were suggesting that for the money we're spending for the population we now cover, we could do a substantially better job of delivering high quality care to close the gap between what healthcare could deliver and what it does deliver by relying more heavily on large integrated group practices organized possibly in different ways. Mayo is different from (off mike) is different from Kaiser and so on.

My question is do either of you, taking that as the objective, see instruments available to public policy to encourage patients to move into such organizations. The presupposes that they're basically correct in their claim of better quality. What could we do to encourage, to bend the playing field a bit to favor that kind of organization?

MR. RISHOUER: You know, if you want to not bend it but force it, you can have conditions of participation in Medicare that say you have to reach certain thresholds of quality.

MS. BAKER: And if you wanted to go in smaller bites in that direction, we've seen a lot of innovation in the Medicaid waiver process for

different types of insurance products, but we haven't seen a lot of experimentation with different rewards for quality through that program.

Maybe that's an avenue to do some experimentation at the state level, because we know that there needs to be a critical mass of providers and consumers who are aiming for that kind of care. We know that the way a patient gets treated when walking through a hospital door is not just a function of that patient's insurance status and that patient's preferences, but everybody else's as well.

We know there are these huge variations in practice pattern that are driven by capacity, that are driven by norms, that are driven by different insurance pools and all of that. So, it's hard to really know from the small scale experiments that we've seen what would happen if an area went more whole scale, full cloth in that direction because we know there are those spillover effects. So, we're not there yet.

MALE SPEAKER: I think there's a huge problem in this sector. If this were mobile phones or trucking or anything else, there would be CEOs and others who would want to expand the business, but I think, you know, when you've come to partners or Kaiser or Isinger or anything, there's limits to the desire of the management to double the size of the patient base or the number of docs in the hospitals they're dealing with.

And so what you want to do is replicate then so that the Boston area has five of these things, you know, then although they all say – and that's a very different challenge for you.

MR. HELLMAN: Thank you all very much for – let me thank the panelists for an excellent discussion.

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