

**BENDING THE CURVE:  
Media Conference Call  
September 1, 2009  
11:00 am. EST**

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**Operator:** Good day everyone and welcome to the Bending the Curve conference call. One note that today's call is being recorded. After today's presentation, there will be a question-and-answer session. You may press star one on your telephone to place yourself in the question queue.

At this time, I would like to turn the conference over to Mr. Mark McClellan; please go ahead, sir.

**Mark McClellan:** Thank you very much and I'd especially like to thank everyone who's joining us today, my collaborators on this report and all of you who are taking time out of your busy schedules to talk to us. Normally, the week before Labor Day isn't a busy time on health care but boy, that's not really true this year.

In fact, talking with a few of the other participants on the call it sounds like many of you have been discussing many of these issues with them on an ongoing basis. So we really appreciate your taking the time to think about a more comprehensive and big picture outlook on how we can bend the health care cost curve while improving quality of care and improving value in care.

On the phone with me today are the other participants – some of the other participants in this health expert effort. Mike Chernew of Harvard Medical School, David Cutler from Harvard University, Mark Pauly of the University of Pennsylvania, and Steve Shortell from the University of California at Berkeley. And these are a subgroup of this group of 10 individuals from some diverse backgrounds, all with expertise in health care over their careers, who came together to talk about our efforts to help bend the curve. This is a term that's come up again and again in recent months as health care reform has focused both on improving access to care and finding ways to make those improvements in access more sustainable.

We wanted to focus on finding a set of reforms that were meaningful but also feasible and that we were confident collectively would reduce spending growth rates significantly. So with those ideas in mind, we turned way from focusing just on short term isolated individual measures, while those – while things like cutting like Medicare prices across the board can have some short term benefits, we don't think that steps like that are sufficient to really bend the curve over the longer term. And we focused on having effects over time. So not necessarily dramatic effects in the next year, but effects that would add up over a few years and over longer time periods for real savings for Americans, American businesses and the federal government and not cost shifting either.

We gathered at Brookings in June to start discussing what we thought would be these key reforms to make a difference. All of us came to this effort with our own experiences and perspectives and from these diverse backgrounds, these different viewpoints, we were able to come to consensus on a set of concrete feasible steps that we believe can slow spending growth while improving quality.

This isn't an exhaustive list as you can see from our document. It's not meant to be. It doesn't necessarily reflect what each of us who have different perspectives would propose individually. But it's meant to be a comprehensive coherent set of strategies that together build on the current health reform proposals in Congress that amount to feasible steps that can be implemented over time to add up to a much bigger impact.

The steps that we outline in this paper are about a few core ideas. It includes accountability and also support for what we really want better care at a lower cost. And we believe that legislation needs to support a set of individual changes to help us get there but again these individual policies add up to the same core goal, a focus and accountability for better care and lower costs, something that's lacking in our health care system today. And support for enabling those changes to lead to meaningful impacts on care.

We divided this proposal with comprehensive strategy into four main pillars. First, we need to invest in better tools to support improvements in care. That includes better information systems, better training systems with emphasis on non-physician personnel and other steps. These steps in and of themselves may not be enough to significantly bend the curve, but they can provide a much more powerful foundation for the rest of the reform in this overall package to ensure that all stakeholders in our health care system can make more effective decisions, can get better care at a lower cost.

The second pillar is reforming provider payments, and this too has been an area of a lot of attention in the recent policy debates. We believe that the reforms and payments should focus consistently on improving quality and reducing cost growth. Right now, our payment systems don't provide very good support for this. We're pleased that there are a lot of steps in this direction and existing legislation, but we lay out a bolder pathway. Not one that means radical changes in the short term, but a set of steps to make sure that we get to this greater emphasis on prevention, on better coordination of care, on avoiding unnecessary services, on getting to better outcomes for patients.

The third pillar is about health insurance markets. All of the major reform proposals reflect some strong bipartisan interest in reforming the way that insurance markets work particularly for people who aren't lucky enough to have coverage through their job. And many of these proposals include reforms in how government subsidies work. We believe that, done right, these steps can create a much more effective competition around better quality and lower cost in health insurance coverage. And can avoid the focus that we have today on risk selection, as well as support administrative simplification and other steps to make lower cost insurance plans available and to reinforce this overall them towards better quality of care and better value for services.

And then finally, the fourth pillar is better support and incentives for individual patients, to give consumers in our health care systems better support and reinforcement for improving their health and lowering their overall health care costs. It's important to see all of these steps as pieces of a comprehensive approach not in terms of just individual incremental changes. These are incremental changes that add up to fundamental change. The individual steps, if implemented by themselves, may not have much impact on cost particularly in the short run. Collectively, we believe the impact can be much larger.

We also have an emphasis on short term investments, in particular, the additional support for things like incentives for providers to invest in health IT systems or to report on the quality of care for the patients that they care for. Those kinds of steps may have some upfront costs. There are proposals to do all of this in legislation that's pending now. What we would like to emphasize is that these steps should not be viewed as individual pieces but as components that can add up to really strong support in the short term for getting to meaningful impacts on care.

So this notion of meaningful use for health IT can be a piece of this. It's got the same goal as payments for reporting on quality. It's got the same goal as payments for reporting on electronic prescribing. It's got the same goal as payments for better coordination of care and medical homes. If we view all of these

as of one piece to get us to accountability for better care and a lower cost, they can have much more impact.

Similarly our insurance market reforms in conjunction with the provider payment reforms reinforce each other. They give both consumers and providers stronger support, as well as better opportunities to get better care at a lower cost. So we believe these should be viewed as having cumulative effects that are bigger than their individual ones.

All of these are related to a few basic themes. This may seem like a long list of proposals but every single one of them is having some inclusion or discussion in the policy debate now. And they all fit into a few core ideas which can be implemented gradually and steadily not with radical change in the short term – and that's what we think helps makes these steps feasible like the gradual reform and the tax treatment of health insurance. And gradual steps to slow down spending growth in very high cost areas, not radical change and not disruption for care that people are receiving now. So that's a little bit of an overview of what's in this report.

What I'd like to do now is turn to my colleagues on this call to talk about each of these four pillars in a little bit more detail. And then we're going to open up the line to questions from all of you. We're going to go through these four pillars in order. And we're going to start, David, if you don't mind with David Cutler, to talk a little bit more about pillar one, the need to invest in better information and tools.

**David Cutler:** Thanks, Mark. And thanks for actually arranging this whole thing as well. I'm going to talk very briefly about what I think of as the cement mixer and the steel rods of this. So the things that had better be there or your building isn't going to stand up. They're not by themselves going to make the building look particularly beautiful, but they better be there and they better be done right.

So what are the equivalent of cement and steel? I think there are a couple of things and they fall under the general header of information and of having the right personnel and being able to then use them right. So why the right information. If you look across the economy, there is not a single industry you can name that you can think of as being very productive, that you think of as good value or having low cost or fewer cost declines. There's not a single industry that you can think of that it's high value without having good information knowing what it does, why it does it, who's doing it, how much it costs, what you're getting for it.

And so what you have to do in the information part of this is lay this foundation for that. There are two big key reforms and then some subcomponents associated with that. The first big reform is to make sure that what we're investing in health IT is effective. We've got a very good start on this, as Mark said. And what we are calling for here is to do more.

The legislation that was passed, the Recovery Act that was passed in the spring, allocated \$30-some billion gross to health IT. And we need to follow that up by making sure that not just – that computers are not just there but they're used appropriately, but that it gives doctors and patients and health systems the right information that it needs. And that we provide whatever technical support is needed to make sure that it's used that way. That's at the individual level is the technology.

There's also the societal use in terms of comparative effectiveness that is taking the information that we get out of that learning what works, what doesn't work, who does better – who does worse in giving that back to patients and insurers and providers. And so the first big part is information. Related to that is someone has to be able to act on that information. And, again, let me draw an analogy from the best industries and the best businesses in the country.

What all of them share in common is that they empower the right workers to make the decisions and to do the necessary changes. In this case, the right workers will be partly physicians, primary care physicians particularly who have been traditionally disfavored. But also non-physician personnel who many studies show are absolutely essential in providing the kind of care that people need, chronic care and transitions and coordination.

And so we proposed creating incentive rates and laws that prohibit this. Aligning Medicare payments so that we support it and reforming graduate medical education payments so that it encourages the right kind of specialties. Again, all of these are ((inaudible)) and we can go into debt on all of them but the common theme of both of these is making sure we know what to do and making sure that the people who are actually in charge of it have the ability and the training to do that. And so that's the foundation ((inaudible)) gets built based off there.

**Steve Shortell:** OK. You want me to pick up, Mark?

**Mark McClellan:** Steve, thanks. If you could go ahead and pick up on pillar two, the transition to accountable payment systems. And David thank you very much for those comments on pillar one.

**Steve Shortell:** Yes, well, David had talked about some of the tools that are going to be needed with IT being the big one. And to kind of continue with the analogy here I'm going to talk briefly about the construction crew. And if you view the construction crew here as being our doctors and other health care professionals and the hospitals and the patients themselves, what we really need, what we're fundamentally talking about here is the need to change the behavior. This is fundamentally about changing the behavior of how doctors and hospitals work together and patient behavior itself.

And that is really going to involve the recognition that the big cost savings in bending the curve will come from keeping people out of hospitals. We can't avoid that. That's the big cost savings and doing a better job of coordinating care, particularly for people with chronic illness. As we all know, the chronically ill are about 75% of health expenditures and we need to do a much better job.

So what we're talking about in terms of the payment incentives is fundamentally changing those over time, moving away from fee-for-service and creating incentives for hospitals and doctors to work more closely together and all members of the health care team. Right now, as we all know, if any one of us goes in the hospital, bypass surgery whatever it might be. They were discharged. Maybe we didn't understand the discharge instructions. Maybe they didn't understand our home environment where we don't have a spouse or someone who can help us with our eight or nine medications and three days later we get readmitted. And the hospital, of course, gets another DRG hit, if you will. They get another DRG payment.

And it's that kind of lack of coordinated care between hospitals, primary care physicians and others that we need to change. So we're trying to create payment incentives that will take that into account.

Some specific examples are bundled payments. You pay for a single condition that might be bypassed, graph surgery, (risk adjust). You factor in differences in area wage rates but basically the hospitals and doctors working together get a single payment for that condition. They hit certain quality measures that are defined in advance but can share in the savings from that. Geisinger Medical Center in western Pennsylvania does that currently. They do that for a number of different conditions now and there's other examples across the country.

Another version of that is episode-of-care based payment. Again, you create a single payment for diabetes over the course of a year. And you have every incentive to keep the diabetics at work, their insulin blood sugar levels in control, out of the hospital, out of the emergency room and you get rewarded for doing that. Of course, total capitation per member per month is another way to go. The Kaiser Permanentes of the world have been doing that for years. There's a number of variations in doing this.

Bonuses for care coordination that Mark has mentioned all fall in to create these patient-centered medical homes using information technology is another way.

What we're proposing here is because we still need to learn more about some of these payment mechanisms and how to respond to them. We're really calling on Medicare to pilot what we call

accountable care organizations that are held accountable for the costs and quality of care. And to set these up as pilots in different parts of the country so we can learn best how to do this.

I think what's really important about the set of recommendations we have is that none of them, as Mark said earlier, when you think about them are radically new. There are examples of every one of them in various parts of the United States. But what we're talking about here is how do you bring them to scale? You cannot bring them to scale overnight. And this is why we're calling for some pilots and for some demonstration programs across the country. But we know they do exist and we now need to see how they can be diffused across the country so more patients can benefit from them.

The other thing I would say is important for us to understand is there then needs to be a connection between these incentives on the delivery system side to reform how we give care, who constructs the building. And on the other hand, from the insurance exchanges and those who have the insurance coverage, incentives for them to choose more cost effective providers. So to choose those that indeed hit the quality targets, then the cost curve at the same time using these new incentives. And this can take place through tiered kinds of co-insurance and deductibles where if you choose providers and accountable care organizations in the top-tier and cost and quality metrics, then you have lower deductibles or they're waived, or you have no car insurance or lower premiums, for example. And so this is one way of walking the bridge between the insurance side and also the delivery system side.

There's a number of other things we've proposed, but I think those are the most important, changing to these accountable payment systems to take advantage of some of these new tools that will be available to providers. So let me stop there.

**Mark McClellan:** Steve, thank you very much. Let's move on to pillar three. Mark Pauly is going to discuss the pillar on reforming the non-group and small group health insurance markets and cover subsidies to go along with them, again, focusing on the same goal of supporting better quality and lower cost.

**Mark Pauly:** Sure. Well, as a reader of Fine Home Building magazine I'm happy to continue with the construction metaphor. The foundation of this pillar, I think, is the – what I call the optimistic postulate that most bad things that happen are not the result of bad people but they're the result of bad incentives and that's probably important when you think about insurance.

And the primary problem with both public and private insurance in the U.S., but especially private insurance, is that the current structure of institutional arrangements does not really provide good incentives to either insurers or employers or individual insurers to make choices that reward high quality and low cost. And so this pillar imagines that there are things that could be done that would help to correct those bad incentives.

One set of proposals involves the creation of insurance exchanges to deal with where the most serious problems are in private insurance in the U.S., which is not in the large firm setting, but it's in the small group and the individual market setting to try to structure both the information available to insurance buyers and the premiums they pay so that insurers are incentivized to compete on cost and quality as their primary objective.

It will probably come as no surprise that the economist party line solution is that an important part of the problem with private insurance in the U.S. currently is the exclusion; the tax exclusion for employer provider health benefits is something that we would propose to change. We don't go into great detail in how to do that but the general principle that it needs to be capped or limited in some fashion is important if insurers actually do experiment in the ways we want them to with better ways of paying providers and better ways of using information. And that does lower the rate of growth premiums.

We want to make sure that insurance buyers are rewarded with, at least, at the margin 100 cents on the dollar of those premium savings rather than as can happen with the combination of marginal income and payroll tax rates and state income tax rates and city payroll tax rates can result in people only actually

pocketing 50 cents of each dollar of savings. And one thing we know about insurance from the point of view of individuals and employers is there's a lot of inertia so that it's going to be helpful to get the savings up front and center.

And so that's important for the private insurance part. It's also important as we propose, as we want to do for improving coverage among the uninsured as we propose subsidies there, it's important that those subsidies themselves also provide incentives to bend the cost curve, that they have some limits on them and don't end up subsidizing exactly the kind of over-treatment and inefficiency that we're trying to avoid for the rest of the population.

And then finally we need to pay attention to Medicare. In fact, Medicare should get it's own house in order, in my opinion, and we proposed a lot of ways to do that. But one of the aspects of Medicare that sort of straddles this discussion is Medicare advantage. And there, we think, there is some virtue in Medicare advantage but that virtue can definitely be magnified by changing the incentives for premium setting and changing the incentives for determining the benchmark payment from the government towards those Medicare premiums through the use of competitive bidding by alternative Medicare advantage plans.

So if you put all of those pieces together, the hope is that the insurance system can be restructured so that people will be able to pay attention to and actually implement the signals about better quality and lower costs that hopefully can be generated elsewhere in the system.

**Mark McClellan:** Mark, thanks very much. And let me turn to Mike Chernew to talk about the final pillar on supporting and encouraging better individual choices.

**Michael Chernew:** Thank you, Mark. And thank you for both convening the group and organizing the call. And thank all of you for attending.

Much of the other discussion that we've had has focused on the details of the delivery system and the financing of care from sort of a provider focus. And this last pillar, if I was handy enough I'd come up with a good housing analogy, but I'm really not. So simply, I'll say much of what this pillar focuses on is what role the consumer has in all of this. And several of the other comments, for example Steve's, have emphasized that in reforming the delivery system and the financing of care, getting the incentives right for the individual, being sort of patient-centric in that way, is a very important component of everything else that's done.

And clearly in the group that you saw assembled I think there's really healthy appreciation for the importance of incentives and the importance of the role of consumers and some of the details about how we might use the consumer to control health care spending are outlined in this section. So the first key reform focuses on the Medicare program and how one might reform the design of the Medicare program.

And I think that regardless of how wonderful you think the Medicare program is – and I'm a big supporter of the Medicare program – I think it's hard to argue that it was put together in a way that really promotes efficiency and cost-effective care. There's a number of things in the benefit package that, I think, if you looked at from scratch, you wouldn't have done that way.

And so the reforms that we talk about with regards to the Medicare benefit design involve sort of getting rid of some of the silos between parts A and B and working through the amount that individuals have to pay at the point of care. So for those of you that know me, it's rare that I say anything definitively and I'm about to say something definitively. We understand that if individuals are forced to pay more at the point of care, they will spend less money. And the fact that there's a lot of subsidies in the system through a number of ways, very generous supplemental coverage packages, for example, causes people to spend more than they otherwise would.

Of course, there's a really rational economic reason why people want coverage and we're very supportive of people having coverage. And so the thing is about benefit design, one has to balance this need to

promote access to care and remove financial barriers with the desire to control spending. And the scene behind our first reform largely is to try and make the benefit packages more clinically sensitive to where we can use the tools that David Cutler spoke about in the very beginning to allow us to create a smarter benefit package.

In the payment reform section, we talk a lot about making payments smarter. And in this section, the analogous point is that we want to make the consumer phase a smarter benefit package, one that rewards them or at least doesn't carry barriers to those things that we know provide good quality care and in some cases financially offsets but doesn't subsidize care, which we think is particularly expensive and not useful, and having the tools in place to do that are important.

And I want to emphasize that in the private sector you see an increasing move towards this; there's a trade magazine out there, there's a picture of Denis Cortese from Mayo talking about how this is done and there's a number of large insurers that have adopted these plans. And you can't go to a conference of employee-benefit consultants without having a number of people interested in the sort of basic topics of arranging co-pays to promote value.

And they're not doing it simply because they want people to use more high-value care, which they do. They're also doing it because they understand that by having more clinical sensitive benefit designs you can sort of try and jointly achieve goals of cost containment and quality of care and bring the consumer along. And that's sort of the first reform under this pillar.

The second reform under this pillar which I think is important is people recognize that there's a connection between individual behaviors and their health. And there's a connection between their health and therefore their spending. And so there are a number of things that we recommend in this document to promote individuals taking behaviors that will increase their wellness.

Now, I imagine when we get to the question session many will ask, well, how much money are you really going to save if you do some of these things like reduce obesity or improve risk factors? And there's sort of growing evidence on that point, although, I think that it would be hard to argue that we are going to fund all of health from these sorts of improvements in wellness. But, I think, as a piece of the puzzle, as a part of what we do, it's important for us to try to manage people's health or at least actually, I would say that more passively. Give people incentives so that when they take certain behaviors they are aware of the beneficial effects.

So, for example, if they reduce their weight, if obesity goes down, it's useful to have incentives such that they might, in fact, reap some of the financial gains that would be associated with that. And so you'll see in this portion of reform a number of things that focus on individual behavior. That allows people to save – to capture some of the savings associated with healthier behaviors and more public health-oriented types of things that try and get incentives right to improve people's health. And, I think, in conjunction with these other activities there, is the possibility of savings.

And finally, and I'll be brief on this last point, there's extensive evidence about difficulties that we have in this country surrounding palliative care. And to the extent that this pillar is sort of the pro-market pillar, although I think all of these have pro-market components to them but certainly there's a lot of pro-market things in this general section that I'm discussing.

To the extent that we want markets to work, we need the information, as David Cutler alluded to. And that requires that we support patient preferences and that they have the information that they need with regards to their palliative care and with regards to various safe harbor provisions to allow people to make choices that are right for them. And we believe if you provide people with the information and appropriate incentives they will make choices that are both right for them and will help us achieve our goals of controlling health care spending.

So I think that very few health economists will argue that if left fully on its own market principles will solve all of our problems, although as a general supporter of the market, I believe there are a number of

reforms all captured in this pillar that become important components to how we bring the consumer along as we try and reform both the organization of care and the financing of care. And we've tried to capture some of those steps in this general section.

So I think I'll stop there and turn it back to Mark and look forward to your questions.

**Mark McClellan:** Thanks, Mike. And thanks to all of you for the comments describing the elements and providing some insights in the elements in this report. I'd like to open this up for questions now. Operator, I'm going to turn that over to you to do it. I just want to make sure we get people to identify themselves when they ask their questions.

**Operator:** Certainly. Ladies and gentlemen, at this time if you would like to ask a question, please press star one on your telephone. If you're joining us using a speakerphone, we ask that you please release the mute function to allow your signal to reach our equipment. Once again, that is star one please.

And first we'll go to Susan Heavey from Reuters.

**Susan Heavey, Reuters:** Hi. This is Susan Heavey from Reuters. I have a lot of questions actually so I'll just try to narrow it down to a couple of ones. Could you talk a little bit more about the comparative effectiveness recommendations here. And how they need to be built upon following that some of that was done with the stimulus act earlier this year, but some really concrete steps that you think are going to be needed to make that work better.

**Mark McClellan:** Sure. The report strongly encourages continued investment and comparative effectiveness research and doing it in a systematic way. There have been some recent reports I and some of the other people involved in this effort were involved in, a recent Institute of Medicine report on identifying some priorities for comparative effectiveness research and we strongly endorse doing that.

I'd like to emphasize that this is about supporting research and making sure that the most important unanswered questions are answered. For example, we talk about areas, focusing on areas of medical uncertainty which doesn't just mean or even mainly mean you know using one particular drug versus another, but also public health interventions, comparing different practice strategies like using medicine versus surgery and also comparing the health care policies that influence practices.

As we outline in this paper there is a good amount of evidence that payment reforms and benefit reforms can lead to important impacts on cost growth but we really want to learn more about those impacts, which patients are affected. How they have their effects and so on. And so it's a broad view of what comparative effectiveness research is.

And then we tie this into the rest of the report. The thing is it's not just doing the research by itself that matters, but if we have changes in payments and changes in benefit designs and changes in liability systems that all put a greater emphasis on better health outcomes and lower overall costs, that means there are going to be more opportunities to use this comparative effectiveness research effectively. And that means that more take up of expert guidelines developed by clinical groups based on the comparative effectiveness research.

It means more of an impact on decision-making by providers since they will be able to get better support if they use IT systems, if they use this information to keep costs down. You know under the current system they don't get paid when they do any of that. They can actually lose money. So it's a synergistic approach to using comparative effectiveness research and having a strong foundation for comparative effectiveness research information there.

**Susan Heavey, Reuters:** And just one other question that I had. One of your key reforms include end-of-life care and having advanced directives. That's been obviously a very hot button issue. Can you talk a little bit more about that?



**Mark McClellan:** Yes. I don't know if Mike wants to add to his remarks, but I think he captured the main point which is we want care to reflect patient preferences. And to do that it's very important to have the kinds of tools we talk about here in place to help inform patients, help them know what their options really are.

And I think you can view our palliative care proposals as related to our more general emphasis on putting individual patient preferences front and center. It's when those preferences get frustrated, when people don't get the care that actually may be best for them that we tend to see higher costs and worse outcomes.

**[Speaker]:** Can I add one thing Mark and I apologize for interrupting on that answer. I think there's some occasionally implicit assumption that under the current system people are making the right decisions and have the right incentives. And, I think, in this area in particular there's a extraordinarily large body of research that suggests that the decisions that are going on now aren't decisions that are being made with the right information or under the right incentives.

And so the area that we talk about, I understand, is very politically sensitive. But I think that any thoughtful reading of the literature would suggest there's incredible room for improvement to improve the ability of individuals to make decisions that really reflect their preferences at what is obviously an extraordinarily difficult time in everybody's life. And that's what we're trying to get at here.

**[Speaker]:** Actually, if I could just add one sentence to that, not only is everything that makes that true but we also have models where people and their families turn out to be happier.

**[Speaker]:** By far. The current system in this is so lacking in some ways that we really do know how to do a lot better. And I think the debate has sort of missed how bad the current system is and what we know about how to make it better.

**Mark McClellan:** And that's why this fits with our proposed payment reforms. It would put much more of an emphasis on patient or family satisfaction with care in conjunction with these kinds of steps to help make sure patient preferences are reflected in medical decisions. Next question.

**Operator:** And next, we'll move on to Jon Rockoff with the *Wall Street Journal*.

**Jon Rockoff, Wall Street Journal:** Hi, yes. Thanks for taking this question. I just had a question about the second step, reforming provider payment systems. Could you just discuss a little bit how the legislation that's out there now, what sort of proposals they're making to do this? And how those proposals are insufficient?

**Mark McClellan:** Sure. As I think we've mentioned earlier, there are a number of elements in current proposals for putting a greater emphasis on accountability. As Steve noted, because we need to get better evidence on what worked best, we would propose some not only pilot authority but a much better capacity to evaluate what kinds of impact different payment reforms are having and then expanding the ones, flexibility to expand the ones in Medicare that are working best. And this doesn't take away any Medicare benefits. And it really would be the hallmark that Medicare beneficiaries are getting better results at a lower cost.

Those kinds of pilot authorities are in most of the legislative proposals. I think they need to be coupled with some strong evaluation authorities too. But if you look further down the list we also have some proposals related to things like putting some pressure on the existing payment systems, which, as you just heard, very eloquently from Mike and David, don't do a good job of supporting the kind of care that people want.

And we want to use both some incentives, some carrots and some not too strong, but some meaningful sticks to get to more of an emphasis on these effective payment systems. So we have some proposals over time to gradually increase the pressure to get from payment systems that don't focus on better

results for patients and lower costs to those that do. And there is some discussion of those kinds of proposals in legislation now but it's not that extensive yet.

We also have some proposals related to medical liability reform which are just now starting to get discussed. And we view all of these as important to implement with the insurance market reforms that focus on the same goal. Steve or others, do you want to add to that?

**Steve Shortell:** Sure, let me just add a little bit, Mark. The basic idea behind all of it is to begin to reward people for getting good results and providing more cost-effective care, rather than the perverse system that we have now, which rewards for simply doing more.

So the evaluation component that Mark mentions is key. We've got to be able to evaluate exactly whether or not these are working in desired directions. And a specific example that is being talked about in terms of pilot is you might take Medicare data for the last three years in which patients, we know they basically go to a series of providers that are affiliated with the single hospital, and so you have them aligned with one of these accountable care organizations.

And you go back in time and look at the cost-utilization risk adjust for it, put in an inflation factor. And that then is the rate for the coming year for that accountable care organization to care for its patients. And if it can do that within that budget limit, if you will. Then it gets rewarded with shared savings and there can be other kinds of rewards for hitting quality targets along the way.

So that's one specific example of a pilot that could be done in various parts of the country.

**Mark McClellan:** And just on that point, again, we're not talking about a radical change here. This would be, as Steve said, shared savings on top of the existing payments that organizations are getting now. We only would move gradually away as soon as we get the experience and as beneficiaries and providers are comfortable with this new kind of payment system. We'd only move gradually away from the way that we're paying now.

**[Speaker]:** And this is not intended to be a report that argues that current reform efforts are deficient in any way. So the question was – had to do with how this reflects on current things. Many of the ideas in this report are, in fact, reflected in various aspects of reform.

**[Speaker]:** Can I just tie the last question together with kind of an observation about how ((inaudible)) to describe our sense. So the view that underlies this report is that medical care is so inefficient that it is both more costly and lower quality than ((inaudible)). And that if we did things right we would therefore spend less and higher quality. And once you say that ((inaudible)) questions about tradeoffs and so on become well, we don't need to deal with those. Let's pick all of the low-hanging fruit.

And what Mark is sort of saying is some of that low-hanging fruit is both easy to pick and leads you on the way to what is a bigger change, but doesn't kind of scare people because it's not ((inaudible)) trying to ration it ((inaudible)) improve their quality and lower their costs. And so it's a question of getting yourself started on that path.

**Mark McClellan:** OK. Thanks. Next question.

**Operator:** Once again, ladies and gentlemen, if you'd like to ask a question, please press star one on your telephone. And next from the *Congressional Quarterly*, Dave Clarke.

**Dave Clarke, CQ:** Just following up a little here. Besides pillar two, you said that there are similar proposals you do see in the current legislation. Could you just maybe briefly point us to some of those?

**Mark McClellan:** Sure. And I'll just go by pillar and I'll just give you a few examples. And if you follow up with Brynn we can provide more detail in specific areas.

But there are proposals for health IT for further support for health IT or paying for reporting on quality in some of the bills, building on say the Medicare pay-for-reporting program and the financial incentives in the stimulus bill for health IT use.

What we'd emphasize is that viewing those as part of a comprehensive strategy to get to the same goal, which is supporting better results for patients at a lower cost is very important. So taking steps to define these in similar ways. The health IT payment could be tied to making sure that a provider has a list of their patients who have diabetes and is able to keep track of that major types of care that they're receiving and their complications.

That would also be a basis for a reporting bonus, at least, in the short term. You add all of these together. It's a significant incentive to provide the bricks and mortar, from the work that David was talking about earlier to support these reforms and payments. And so those are in – those kinds of proposals are in some of the existing legislation.

We talked about pillar two. In pillar three there are some proposals out there related to the key idea of reforming the tax treatment of employer health insurance. This is an important one that, again, needs to be handled gradually to be workable for the public and for employers and unions. But there are some proposals out there that would either start a cap at a very high level and gradually have it phase in over time by not increasing with the full expected growth in health care costs. That would help keep spending growth down.

Or there's some proposals for imposing fees on relatively high cost insurance plans. Again, this can be done in a way that's gradually phased in over time as well.

So those are important reforms. There are some ideas for including forms of competitive bidding in Medicare in the health plan choices in Medicare that relate to our proposal here. I think you know Mike said it earlier and Steve too, that these are not fundamentally new ideas in most cases. But they do fit together into a more comprehensive strategy that's a limited number of core ideas that can be implemented gradually to have a much larger effect over time than any one of them would have alone.

Do you all want to add any other comments about specific proposals?

**[Speaker]:** Well, I'll just add one. There's a bill sponsored by Senator Hutchison and Stabenow in value-based assurance design which talks about using incentives more – in a more clinically sensitive way. We can talk at another time about some of the specifics of the bills, but I think you'll find a lot of these in specific ones.

**Dave Clarke:** Thank you.

**Operator:** And next, we'll hear from Jim Landers, at *Dallas Morning News*.

**Jim Landers, Dallas Morning News:** A question about the fourth direction of this which is, as I understand it, the incentives for better wellness behaviors. Do the people who are provided these incentives have sort of a pre-existing circumstance? They're smokers or they're obese or what not? And that their premiums will then be adjusted according to measurable improvements that they realize in those conditions? Or are they going to start with a higher premium than non-smokers, non-obese people.

**Mark McClellan:** I think Mike can talk about this in a little bit more detail but many of the employers and private health care systems that have implemented these kinds of reforms try to make them personalized. So they have different kinds of goals that are appropriate for different kinds of people who have – who differ in their risk factors and their health status.

**Michael Chernew:** Yes. And I would simply add this is an area where the research is rapidly evolving and people do it in many different ways. But one has to be very sensitive to issues around how you're providing incentives to people for their behaviors.

And if you look at our proposals we actually are relatively weak. Some of them are broad proposals that aren't targeted in the way that you are speaking of, things like taxes on sugar, sweetened beverages. But others are phrased more in terms of piloting an evaluation. And again in the private sector, there's an incredible amount of innovation in this area, particularly, amongst large employers in doing these types of things.

And what we're proposing here is not a specific reform that should be structured in a very specific way, in part, because we're not sure what the best way to do those are technically, let alone, politically, but, instead, in the spirit of gaining more information, in the spirit of promoting a sort of system where people are both healthier and less expensive to care for. Allowing demonstrations and evaluations of different are ways of doing these. Some of them are community-based, some of them less so. But we have not sort of specified exactly that this should be the penalty if this is your BMI.

Many programs, for example, focus on your effort as opposed to the result. Others give a reward for a number of behaviors. But the details would have to be worked through in the pilots much more so than we did in this document.

**Steve Shortell:** Just to build on what Mike has said. This is Steve. The early evidence in terms of the interventions having to do with the diet, the physical activity, and tobacco cessation suggests a five to one return. For every dollar invested, there appears to be a 5-fold return.

But as Mike has said, we really don't know what specific kinds of interventions or combinations of interventions might yield those kinds of returns consistently over time. So far the evidence has been limited to these having to do with these behavioral lifestyle kinds of interventions. We need to know much more.

But you know as we try to get and pin dollars and what are going to be the savings over time? It's this kind of evidence from well-designed evaluations that give cause for optimism here that this package of proposals that we're talking about that Mark mentioned that reinforce each other actually, we have some confidence in, will slowly over time bend this cost curve. And that's one part of it.

**Mark Pauly:** This is Mark Pauly. I actually usually advise employers, at least, first to frame these as carrots rather than as sticks for all sorts of morale reasons. But one way to frame it, that sort of splits the difference is to say, well, of the increase in premiums that would otherwise be the case, if you undertake and participate in these programs and have success, you'll be cushioned somewhat against that increase.

**[Speaker]:** And our specific recommendation is one of premium rebates that allows everybody the opportunity to save by doing various risk factor improvements. We've just not yet been specific on the details of all of that. But it is phrased as a carrot and one that's broad-based.

**Mark McClellan:** OK. I am told that is our last question. Let me thank our participants, again, both those who are on the call and the rest of the co-authors of this report. If you all have any follow-up questions on specifics or need some clarification, Brynn Barnett at Brookings is a good point of contact. I also expect that the collaborators who are on this call will be happy to answer any follow-ups too.

Thank you all again for joining us and thank you for especially for your attention to this very important aspect of health care reform.

**Operator:** Ladies and gentlemen, that does conclude today's conference. We thank you for your participation. You may now disconnect.

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