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**Report Release on Estimated Savings from
Specific Healthcare Reform Options
Commonwealth Fund's Commission on a
High-Performance Health System
December 18, 2007**

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KAREN DAVIS, PH.D.: I'm Karen Davis, President of the Commonwealth Fund. Thank you for being here this morning and for having an opportunity to share with you a brand-new report from the Commonwealth Fund called, "Bending the Curve: Options for Achieving Savings and Improving Value in US Health Spending." The report was prepared by Commonwealth Fund staff for the Fund's Commission on a High-Performance Health System.

I'll provide some brief background before turning to Cathy Schoen, Senior Vice-President at the Commonwealth Fund and lead author of the new report, to present highlights. And then Dallas Salisbury, who is President and CEO of the Employee Benefit Research Institute and a member of the Fund's Commission on a High-Performance Health System, will put these findings into a broader context. We'll then turn to questions and answers and we'll be joined by other authors of the report. Dr. Tony Shih, Assistant Vice-President of the Commonwealth Fund in charge of our Quality Improvement and Efficiency Program, and Stuart Guterman, who is Senior Program Director of our Program on Medicare's Future.

For those of you who don't know us, the Commonwealth Fund is a private foundation that supports independent research on healthcare issues. The Fund's mission is to promote a high-performance health system that simultaneously achieves better

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access, improved quality and greater efficiency, especially for our nation's most vulnerable populations.

In 2005, the Commonwealth Fund Board of Directors formed the Commission on a High-Performance Health System with the charge to support research and provide information that would help policy makers and the public and private stakeholders address problems arising from our fragmented healthcare system and move us toward greater access, quality, equity and efficiency.

"Bending the Curve" is the latest in a series of three reports this fall created to set out recommendations for the next President on priorities for healthcare reform.

The first, "A Roadmap to Health Insurance for All: Principles for Reform," was released in October. It made the case that coverage for all Americans is the most important step to achieve a high-performance health system and recommended a mixed private/public system as the most pragmatic way to reach that goal.

The second report, released in November, "A High-Performance Health System for the US: An Ambitious Agenda for the Next President," made the case that while guaranteeing affordable health insurance for all is the number one priority, the next President must also focus on: Improving the quality and efficiency of care by reforming our current payment system

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to reward hospitals and physicians for providing high-quality, cost-effective care; organizing and coordinating care delivery so that patients can easily navigate this system and across providers; investing and implementing an electronic health information system in a reasonable period of time, and the Commission aimed for five years; and establishing national goals and doing what it takes to reach them through strong national leadership and public/private collaboration.

The next vital step to move the US toward a truly high-performance health system is to address the problem of rising healthcare costs that are putting our nation's economy and health insurance coverage at risk. The report we are discussing today kicks off that important and difficult discussion by providing models for achieving the savings that will allow us to get real value from the \$2 trillion we spend each year on healthcare.

While the US spends twice as much per capita on healthcare as any other nation, we are not getting good value for our dollar. Looking within the US, the Commonwealth Fund's State Score Card on Health System Performance found wide variation and quality of care among states, and that higher costs are not associated with higher quality.

Looking outside our borders, the Fund's Annual International Health Policy Survey, conducted for 10 years, has

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consistently found the US falling short on many measures of quality, safety, access and equity when compared to other countries, despite the resources we put into healthcare. Healthcare in the US now accounts for 16-percent of the gross domestic product and is on a trend to rise to 20-percent in 2016.

"Bending the Curve" is, I believe, one of the most important reports the Commonwealth Fund has released. It gets to the heart of the question, will we continue to head down a path of less access to care for millions more in our country, higher healthcare costs, poorer health for too many Americans and poorer returns on the resources we are spending on healthcare? Or, will we start now to make the changes needed to transform our healthcare system and ensure our future prosperity as a nation?

And, with that, I'll now turn to Cathy Schoen, Senior Vice-President of the Commonwealth Fund and Research Director for the Commission on a High-Performance Health System. Cathy?

CATHY SCHOEN, M.S.: Thank you, Karen. I'm delighted to join you on behalf of our author team and also the Lewin Group, who provided all the estimates for the report – and John Shields is with us today as well – to present the results of this report.

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As Karen said in her introductory remarks, the US is current on a trajectory of doubling the amount we are spending on healthcare, going from \$2 trillion to over \$4 trillion over the next 10 years, rising to 1 out of every 5 dollars. And at the same time, millions are losing coverage or becoming underinsured. We clearly are not getting high value in return for the investment we are now spending, which outstrips every other nation, because we persistently see wide variations in quality, wide variations in efficiency, and symptoms of poor performance.

The goal of the report we are issuing today, which is an options report looking at concepts, is to focus on total national spending and look at ways that we can reduce and moderate that growth, while also improving value, in terms of quality, access and population health. We hope that the report will stimulate an informed debate and also lead to consensus building around actions we can take now to address national healthcare costs in a manner that would yield higher value.

The report is unique in that it examines the impact on total national health spending in all sectors, not just federal costs. We are all in this together, public and private sections, households and businesses. All are facing the same healthcare marketplaces that are yielding high and rising costs. The report focuses on a range of federal options with a

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potential to moderate spending growth and improve value.

Wherever possible, we looked at options and concepts that potentially gave win/win results, where we got lower spending growth in the future, as well as better returns for the investment in health.

Finally, the report illustrates the potential of a multifaceted approach, of combining different conceptual approaches to underlying factors that are driving up costs, with affordable coverage for all.

Overall, the report findings indicate that it is possible to insure everyone in the United States and achieve substantial savings, better value, better quality and safer care. Strategic options combined with coverage for all could save and estimated \$1.5 trillion cumulative over 10 years. This is adding up the annual savings in each year over this decade. Moreover, savings to the federal government from the targeted saving options could offset the federal costs of extending insurance to all.

Bending the curve is possible, as we indicate in the report, but it's also important that we start now. Each of these options accumulates over time as we learn by doing. The sooner we start, the faster the investment, which some require, will start to yield return.

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Turning to the options in your report, in the handouts you were given as you came in, you have both an executive summary and a long report. We summarize in the main report each of the 15 options, but I urge you also to look at the specifications and the details because they are all conceptual approaches that we had to estimate, so we had to get specifications in order to allow Lewin to model them.

We have 4 major strategic areas and 15 options. The first major area is producing and using better information. This includes options such as health information technology to support physician decisions, but also to exchange information as patients move across sites of care, as well as a Center for Clinical Effectiveness that could tell us more about what works well and for which patients.

We have options that promote public health initiatives, as well as disease prevention, with positive incentives through benefit designs for patients to help manage their own health and prevent disease.

We have options that look at the way we pay for care and provide positive incentives for quality and efficiency, including enhancing the way we pay for primary care to allow primary care to be stronger in terms of access and coordination of care.

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Finally, we have a set of options, "Correct Pricing Signals in the Healthcare Marketplace: Sending Positive Signals for Lower Cost and Better Efficiency." This includes addressing the wide geographic variations that we see across the United States.

As I said at the outset, the report includes a total of 15 options, each aimed at achieving savings and increasing value. The estimates by the Lewin Group look at annual impact for each of 10 years at the national level and also look at the distribution across major payer sections: the federal government, state governments, employers and households.

We also looked at what would happen if we combine the strategic savings options with an option, a scenario of affordable coverage for all. For the coverage option, we looked at a possible insurance connector approach, pioneered by Massachusetts, which builds on private and public group health insurance. In this national insurance coverage approach, the connector would be offering a structured choice of plans and also a Medicare option to individuals and small businesses.

The 15 options to achieve savings are listed on this slide and detailed in the report. Over a 10-year period, they save anywhere from \$9 billion to over \$300 billion. Many include initial investments, such as in health IT, where we're

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initially spending money and over a three or four-year period start to get a return on that investment.

When we combined strategic options from better information, public health healthy incentives and payment reform on a base of universal coverage through an insurance-connector approach, we see the potential to save more than \$1.5 trillion over the 10-year period. But, as illustrated in this slide, that's an enormous sum that accrues from year-by-year savings that are often quite modest. First-year savings are around 1-percent off projected trends. As you go out to the tenth year, we're about 6-percent off projected trends, so we are bending the curve by reducing the rate of increase.

As illustrated on this chart, we succeed in bending the curve about half-way from the projected 20-percent of national income we would be spending and the 16-percent we are now spending. But, what we are getting for that investment, if we could succeed on each of these strategic areas and insure everyone in the United States is better access and better, quality as well as moderated cost growth and better health outcomes.

Moreover, the savings to the federal sector by the strategic savings options could offset the costs of expanding insurance for all. By the out years of an expansion, if coupled with strategic system reforms around information,

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population and health and incentives in payment, the net costs to the federal government could be modest or negligible.

In closing, these are several cross-cutting themes and conclusions emerge from assessment across the options. First and foremost is covering everyone and achieving savings with better value, in terms of quality and health outcomes, should be possible for the country. However, addressing and achieving these savings will require a focus on total system cost, not shifting costs. This will be key to long-term improvement. As I said initially, we are all in it together. We are all facing the same rising costs. It's going to require a collaborative public and private view, in terms of looking at what we can gain for the nation.

Each of the individual options yields modest savings by themselves. There are no magic bullets that alone fully address sources of efficiency and rising costs. It will take a multifaceted approach, combined with well-designed insurance, to substantially improve performance across all dimensions of the healthcare system. Moreover, value is much more than just dollars. Some of the investments in these options yield substantial gains in quality and safety, so they should not be judged by just the dollar value alone. Achieving this type of savings and achieving the long-term gains that are possible will require every stakeholder to play a part. It has

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to be a shared-responsibility approach. And, last but not least, we need leadership to build consensus. Looking across sectors, collaboration is possible. We both need to come up with conceptual designs and also implement them well. The stakes are very high if we should fail. Both the health and the economic security of the nation are at stake if we continue on the current path of rising costs and falling coverage, but we, as a nation, can look toward opportunities to improve health and achieve more effective, more efficient and more equitable care. Thank you.

I just want to acknowledge the co-authors who will be coming up to the stage. John Sheils I mentioned earlier. The Lewin Group did all the modeling. John is in the back row. I'm not sure if there's anyone else from Lewis is here, but John Sheils, Randy Haught and Jonathan Smith were critical to bringing you the estimates we're bringing you today. Thank you.

DALLAS SALISBURY: Cathy and Karen, I thank you both. It is, for the Commission itself, very exciting to have this Options document set forth. As Karen noted, the Commission views this as options, not recommendations, as it is doing this analysis and future analyses to try and get to the point of assessing what it might want to recommend.

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The message of this report, as far as I'm concerned, is the underlining of the degree to which we, as a nation, can – should we wish to – actually move down a road to reform and increase value for individuals and basically continue to provide healthcare and healthcare for a rising number. As opposed to the alternative that was presented yesterday in the next room by the controller general of the United States, in underlining that the choice was not necessarily from a fiscal perspective of maintaining the current system, but there might be the necessity of saving that entire that \$2 trillion, in terms of simply sustainability of the system.

Slowing the rate of growth and finding value in the system through providing coverage for all, coverage that – as he noted yesterday, we're already, for large number of the population, paying for in the system – is extremely important. These options, which save \$1.5 trillion over the full period, help towards that objective. The other thing that these charts clearly underline is that it is extremely important and critical that the nation initiates a comprehensive reform effort now. Having come to this town and begun working on these issues in 1974, I've heard that statement made many, many times. It's underlined that ultimately, if we don't start now, the nature of the changes necessary and the potential for the political process to feel the need to simply reduce services –

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the system suggests that that might be where we would be. I think what the Commission is working so hard to do and what this analysis underlines is that there's an alternative to that. We can bring efficiencies to the system. We can work on healthcare financing and delivery if we do it now with the prospects for the time to implement.

Businesses and working families, as well as public sector, face the dilemma of looking to the future. We, as a nation, already spend more than any other country in the world by any measure, per capita or otherwise. Essentially, that argues for trying to deal with this now.

What this report does that is so vital is, for the first time, it illustrates in a comprehensive way and puts numbers to it that we can, in fact, have the prospect of bending that cost curve by bringing greater value to the system and, as a result, hopefully allow more people to have more healthcare without it leading inexorably to simply tax increases.

The stakes are extraordinarily high if the nation fails, as Mr. Walker noted yesterday. If one doesn't find ways to either triple taxes, for example, simply for Medicare or reduce Medicare benefits by 50-percent, the only way to have that balance is by bringing value to the system. This report

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tries to put forth and analyze options that would increase those values.

Policy makers in all sectors will have to, however, have the courage to stand up and begin to take action now. This report shows they have lots of options. We need to help them find the will. As Cathy noted, 15 options are explored. Other ideas will be developed and will be evaluated in the months ahead to provide the Commission with a broader set of options than is just here.

While no magic bullet exists, as Cathy underlined, if we don't start now, we won't ever reach the point we need to reach. The Commonwealth Fund's Commission on a High-Performance Health System asked that this report be prepared, as noted, as a first step in multiple option analyses to try and help us in our deliberations in the future. In the meantime, as noted, we hope it will begin to stimulate debate. It will raise the standard for those that are engaging in the debate and challenge them to attach numbers to what they are engaging in, vis-à-vis rhetoric, and will help them focus on the necessity of quantifying how alternatives and options have the prospect of bending the curve, in order to extend sustainability of existing programs and add value to the system.

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A couple of key points – this report underlines that all sectors and all individuals, be they business, families, state and local governments or non-profits, are in this together. Health cost growth is outpacing wage and income growth. It is at a much higher rate than general inflation. It is putting pressure on employers and putting pressure on individuals and government.

One company that will be presenting at an upcoming event put out a report recently and underlined small company IBM and how two-thirds of its full employment is now outside of the United States, yet 85-percent of what it spends on healthcare is within the United States. That means that one-third of its employees account for 80-percent of its health spending. In a global environment with increased competition, that is a fairly stark statement.

For workers, if they look at earnings adjusted for inflation, they find that they've been nearly flat for 20 years and have even declined for low and middle-income individuals. Part of that is due to health spending. A recent survey that EBRI undertook found that of the 60-percent of American workers that report increased health spending required of them in the last year, over 50-percent paid for it by either borrowing or reducing what they were saving in 401k and other programs. So, we're all in this together, not just vis-à-vis health policy,

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but relative to the total economic well-being of workers and future retirees.

If we look at premiums, since 2000, average family premiums have grown over 81-percent, even as the proportion of total national spending out-of-pocket has slightly declined. Yet, median incomes are up only 11-percent as that health juggernaut goes on. As I just noted, how are we paying for it or how are individuals meeting that challenge? It's through personal debt – 18-percent did it through credit cards and 17-percent through home equity lines of credit. Given the mortgage crisis, that line of financing for individual health needs probably will be less available in the years ahead. So, the challenge for all of us and the importance should not be underestimated. For employers, rising premiums are creating those same challenges and probably accelerating the issue of jobs overseas.

As a second point, we all clearly benefit from value and from high-quality healthcare. We clearly value it. In our surveys, 87-percent of employees underlined that if there was only one benefit they had at work, other than salary and vacation, it would be health insurance benefits. Employers know that they cannot axe it [misspelled?], the provision of health insurance. Politicians know that they cannot axe it, a

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government involvement. That underlines the need for these options and this type of comprehensive analysis.

Third, we should be able to get much better value for the money we invest in healthcare. Institute of Medicine reports in recent years have underlined both the quality chasm, as well as the amount of wastefulness in the system. Hopefully, the Commission sponsorship of this analysis will add to that work of the Institute of Medicine and so many others in helping to move the nation and decision makers towards this understanding of the necessity for action now, not many years from now.

Fourth, this isn't something that one group or one sector of the healthcare system can do on its own. We know from watching the Congress even in recent weeks that clearly federal action alone cannot do it. Employers have underlined that they do not frequently have the leverage in their communities, even very large employers, because they have their workforces – as with IBM – not only spread around the world, but that third of their workforce that is in the United States is dispersed across all of the states of the United States. And so their ability to bring leverage to the system is extremely light. That is why this report underlines the potential leverage which changes in the Medicare and Medicaid payment systems can have, and the degree to which changes in

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negotiation and in the form of negotiation undertaken by federal government programs can play through the system to advantage the entire system.

Fifth, it underlines that well-designed insurance coverage is essential to moving forward to achieving savings, to rationalizing the financing of the total system. To the extent the insurance expansions build on group coverage and bring insured groups together, payment and other reforms would apply to a much larger population and thus bring the ability for leverage in the system.

As a member of the Commission, my hope is that the options in this report will lead others to quantify, will lead politicians to understand that broader sets of analyses are needed, and that specific actions need to be underlined and set forth. As Karen and Cathy have noted, the Commission's goal in asking for this report is that it spark constructive national debate sooner, rather than later.

Building consensus to move in a healthier direction will require leadership. One of the objectives of the Commission in this report is to encourage all political candidates moving towards the 2008 election to begin to exhibit that leadership. This report outlines in clean economic terms what the nation stands to lose by maintaining a status quo health system, and what we have to gain if the policy makers in

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all sectors have the courage to being collaborating now on a comprehensive strategy for health system reform. In my view, it is a call to action. In the Commission's view, it is a call to action. In the Commonwealth Fund's view, it is a call to action. And we hope that it will begin to take that call to action to actual action. And this analysis will hopefully help do this.

It is my pleasure to now invite up the other study authors and to turn the program back to Karen, who will moderate the Q&A. Karen?

KAREN DAVIS, PH.D.: Thank you, Dallas. As we mentioned, Dr. Tony Shih and Stuart Guterman are also joining us for any questions that you might have. If you would, please identify yourselves and we'll open up the floor at this point to any questions you might have. Yes?

BRUCE KELLEY: Hi, I'm Bruce Kelley with the Mayo Clinic. Am I correct that each of these options was scored independent of one another? In other words, you looked at each option, assuming that nothing else on this list was also part of the mix. Is that correct?

CATHY SCHOEN, M.S.: The question was whether they were estimated independently. The answer is yes. When we did the combination approach, it was still basically first-order effects. We think, therefore, it understates the potential

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gain because modeling the potential dynamic or synergistic effects – for example, having health information technology and a Center for Clinical Effectiveness and insurance for combine and reinforce each of the incentives in a more synergistic way. But even in the combination effect, we looked more at the additive, independent effects, rather than the synergy.

TOM MILLER: Tom Miller, AEI. This may be Stu's territory. Looking at your policy reform options – you had about four of them for Medicare – you kind of look at the way you did the cost savings. There's one where you kind of tease this out a little bit further. It appears that you give some significant savings – and I'm giving a little bit of value judgment here – in terms of the competitive bidding approach. It doesn't save you as much money as reducing the high-cost areas, but it looks like individual beneficiaries are choosing to spend more because they get better value for it. Could you kind of walk through those four different ranges of options for Medicare spending? We've heard a lot about kind of just re-setting the payment rates to Medicare alone, which is the low-saving option. I think that's the way you outlined this. And you had some concerns about cost shifting if you go to kind of more of an all-payer approach or the high-cost area limits. Please kind of walk through how you look at those options.

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STUART GUTERMAN: Sure. On the competitive bidding option, you do, indeed, get more savings than if you just reset the benchmark rates. The option that we looked at would have the rates that are paid to Medicare Advantage plans set according to the bids that the private plans submit and also make the traditional Medicare program part of that picture. So, in fact, in the discussion of the option in the report, we point out that one of the potential problems with that is certainly that some beneficiaries who choose to stay, either in higher-cost private plans or in the traditional Medicare plan in areas where that might be higher cost than the private plans, would then have to pay out-of-pocket to stay in those plans. Clearly, if that policy were developed and implemented, some action would have to be taken to protect those beneficiaries who are more likely to be in poorer health and so on. But there are certainly potential savings from that. Resetting the benchmark rates, that is certainly something that would save, based on the fact that Medicare Advantage plans now are paid considerably more than fee-for-service in the traditional Medicare program would expect to spend for the same patient.

For the all-payer provider payment methods and rates, you'd basically have a policy aimed at reducing the cost-shifting among the different sectors. Currently, private

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payers tend to pay much higher rates, partly to offset the losses from uninsured patients and Medicaid in many places. What this policy would do would be to reduce the growth rate of private payer rates and increase Medicaid rates until they both sort of met the Medicare levels. But, again, as we point out, you'd have to take some action to make sure that the providers who treat a lot of uncovered patients – that issue would have to be addressed in that policy.

KAREN DAVIS, PH.D.: So, again, it's an example of an option where if you did it alone it would have a somewhat different effect than if you did it in the context of health insurance for all. For anyone interested in the details on the competitive bidding and the impact on beneficiaries, it's on page 49 of the spiral-bound, long version. Other questions? Yes, if you'd identify yourself?

MICHAEL POSNER: Mike Posner, *National Journals Congress Daily*. On the chart, the chart shows total health expenditures going to \$4.4 trillion and savings of \$4.1 trillion – \$300 billion. Why is it going all the way up to \$4.4 trillion? If it's 16-percent of GDP now, why is it rising so fast?

CATHY SCHOEN, M.S.: I'll take a stab at a short answer. The projections of going to \$4 trillion have been out for at least a year now. They've come out of the Office of

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Actuary for the US and Lewin has modeled off of those. They're rising for multiple reasons, not the least of which is the way we pay for care. When we look at underlying factors, the prices we pay have been going up rapidly, the amount of services, the intensity of services has been going up. If you adjust for age, we are a relatively young population compared to other countries which are much older. So the fact that population is aging is somewhere underneath, but has a very small effect. So that projection of the long-term trend is continuing based on what we've seen for the last couple of decades. That's how you get to the \$4 trillion. It's not that we know for sure that we'll get to that \$4 trillion, but that is exactly the path we've been on so far.

MICHAEL POSNER: With a \$1.5 trillion savings, one of the major conclusions with this – if you're really strict with the cumulative – it's only really going to be \$300 billion by the out year.

CATHY SCHOEN, M.S.: That's actually correct. The question was that the annual savings in any one of these years is relatively small. He was looking at the tenth year, which is around \$300 billion. When you add it up, \$1.5 trillion is an enormous sum. The reason it looks relatively small on this chart is because the base is so huge. On a \$4 trillion base,

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if you can take a percent or two or three off, it amounts to billions of dollars. And those are real dollars.

MICHAEL POSNER: One more question. One of the largest savings is from something called the Center for Medical Effectiveness in Healthcare Decisions. What is that?

STUART GUTERMAN: First, I'd like to add a point to put that \$1.5 trillion in perspective. Let me point out that currently we're projected to spend \$33.3 trillion over the next 10 years on healthcare, so that's the amount of money that's on the table that we have the challenge to at least use better and more efficiently for our population.

The Center that we describe in the report is an entity that would produce better information to be used for clinical decisions, for payment and coverage decisions, and also for decisions to be made by patients as to the appropriate treatment that they'd be looking for for particular conditions.

Also in this option, we build some teeth into the policy by having higher co-pays for procedures and treatments that don't have an evidentiary base, so that if people wanted to have a treatment that didn't have any evidence that it was going to be effective in their particular situation, they'd have to pay more out-of-pocket to do so. Also, there would be a requirement that physicians engage patients in shared decision-making processes so that we could make sure that

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information was injected into the decision-making process.

[Inaudible].

We hypothesized in this option one particular formulation. There are a number of proposals for this kind of entity that are floating around and, in fact, several are built into some of the legislative proposals that have been made in Congress and there are other ideas. So there are a lot of ways to do this, but the essence is to produce better information and to find a way to get it injected into the decision-making process so that it can actually be effectively used.

KAREN DAVIS, PH.D.: Other questions? Yes, in the back, if you'd introduce yourself?

FRANK CLEMENTI: Hi, I'm Frank Clementi, consultant. You have up here your insurance connector. Could you explain what inefficiencies that addresses in the insurance marketplace and what the cost savings are connected to that proposal?

CATHY SCHOEN, M.S.: Yes, if everyone heard the question, it was, in the insurance scenario that we looked at with an insurance connector, where are efficiencies from that particular proposal? In the design, as we specified it, there would be a new national insurance connector that would be offering integrated health plans and also a Medicare option. The Medicare option would be using the current Medicare claims administration systems, avoiding mid-level intermediaries and

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just directly contracting with claims administration, and would be paying Medicare provider rates and offering a community-rated plan to small businesses and individuals as an option in competition with private-sector options that are available.

The efficiencies that come directly from that are some administrative insurance cost efficiencies and payment levels. Stu just described the free-standing option of all-payer. It brings Medicaid rates up to Medicare rates to try to promote equity in the way providers are being paid. So, if I see a patient, I don't get differential payment purely by the insurance source. So, the one source of direct efficiency is on insurance administrative costs and collective, but what happens when you combine it – and we were asked about the more synergistic effects. If you imagine that everyone is covered, all the types of payment incentives that can now apply just to the Medicare population if the federal government did it, unless private sector piggybacked, which they can always do, would automatically start to apply to a larger share of the insured population while its uninsured if the rate offered by the connector was attractive. The estimates are that a large share of the individual market and small business market would come in because the premium rate would be a good buy for the benefit package, compared to what you can currently get, so

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there's a new competitive dynamic in the insurance marketplace as well.

JONATHAN PECK: Thank you. Jonathan Peck, Institute for Alternative Futures. Given the great disparities between the burden of morbidity of the poor versus the wealthy, are your analyses accounting for that at all, or they assuming basically an equality from an economic standpoint of the population?

CATHY SCHOEN, M.S.: We didn't change an assumption about the starting place so that we were starting with the distribution of chronic conditions according to income. In out years, because of the public health initiatives that we've built in, to the extent that those affect particular population groups more than others in out years, the health of that population would be affected and improved. Insurance coverage is also part of the equation. We did not model a direct effect on health outcomes from insurance coverage, but we know that low incomes are much more vulnerable to being without coverage intermittently, as well as long term. Getting people in earlier, especially diabetics, to see physicians that now have decision support on maintaining diabetes should have a long-term health impact, but we did not directly model health impacts, other than the direct public health initiatives.

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JONATHAN PECK: So it may actually be understated?

CATHY SCHOEN, M.S.: Absolutely. We should be able to decrease some of those health disparities by a combination of better access and better quality care.

KAREN DAVIS, PH.D.: But I think implicit in your question is that we're looking at savings to healthcare spending, the impact on national health expenditures. We're not looking at savings to the economy from improved productivity, fewer work loss days, fewer sick days, early retirement as a result of preventable morbidity or disability. Definitely, I think that when we look at the Institute of Medicine's report, it's showing that there is \$65 to \$130 billion in savings each year that can come from the economic benefits of coverage of the uninsured. This is just looking at savings in the health sector, not at savings in the broader economy. Yes, we'll go back to Brian.

BRIAN: Two of the proposals here, the connector and the competition among Medicare Advantage plans, put Medicare fee-for-service in the mix as a competitor, if you will. I'm assuming that that means that Medicare in its current configuration, which basically sets its own prices – so how is that really a competition in the way that you view this?

CATHY SCHOEN, M.S.: In the context of an insurance connector in broader areas, it would be putting Medicare in its

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current formulation, but private sector, similarly, is now piggybacking and always has, such as when Medicare innovated with DRGs and starting bringing in innovative payment methods. So, to an extent, if the private sector plans also innovate and find different ways of paying, embedding different incentives and moving away from a fee-for-service, we could get a dynamic competition in place that is quite different than what we see now. Part of the competition now is reducing coverage or not covering sicker people. In a world of health insurance, that would no longer be an option if everyone was in. But yes, it's putting in a dynamic that has a central Medicare program where providers choose to accept payment in full or don't choose to accept payment in full, in terms of networks as well.

KAREN DAVIS, PH.D.: It may be stupid to say a bit more about one specific example on the hospital pay-for-performance, but implicit in that option is information on performance of hospitals, so transparent information on different hospitals' performance in quality and efficiency. To the extent that Medicare then makes that public and designs its policy policies to reward that, it certainly makes it much easier for the private sector.

STUART GUTERMAN: Also, you need to remember that these are not proposals. They're options. But there is nothing in the option that we happened to have modeled that would be

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inconsistent with improving the benefit structure and other aspects of the Medicare program or with improving the level of competition between Medicare and private plans, both for Medicare beneficiaries and for people who are not enrolled in Medicare. We took as a base what currently exists, which is another way that we may be understating the potential benefits of this kind of system.

KAREN DAVIS, PH.D.: All the way in the back over there?

PATRICIA SMITH: Patricia Smith, Alliance of Community Health Plans. I have a two-fold question. A number of the strategies that you've outlined are ones that require upfront investment, and that investment in the system has always been something that's a stumbling block because you have to put money on the table first. I'd be interested in knowing how you account for that and how you look at that over the longer run. Secondly and sort of building on that, going back, Cathy, to your original comments about synergistic effects, I'd be interested in hearing how that may build on the answer to what you're doing upfront in the system and what kinds of synergistic effects may take place over the longer term to create a more holistic system.

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KAREN DAVIS, PH.D.: Tony Shih, I don't know whether you want to use the example of the information technology on upfront investments.

ANTHONY SHIH, M.D., M.P.H.: Sure. One of the examples that requires upfront investment is the policy option of promoting health information technology, in which the option specifies a 1-percent levy on private insurance premiums, as well as 1-percent of Medicare expenditures.

On the question of how we can address that, I think one of the key messages of the report is that individual stakeholders have to look beyond their individual silos and focus on potential national gains in value. This is an instance where, upfront, yes, the payers have to put in money. Over 10 years, actually, there is a net savings to the federal government. And by the eleventh year, there will be a net savings to the private payers from their initial investment in healthcare.

KAREN DAVIS, PH.D.: Cathy, is there anything that you wanted to add?

CATHY SCHOEN, M.S.: No, other than, as Tony underscored, it's looking at the potential for group gain. If we all look back, we wouldn't have a national highway system if we hadn't decided at some point that we needed a highway system. It was in the public domain because the benefits

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accrue to everybody. It was everybody participating to make that infrastructure possible.

DALLAS SALISBURY: I'd like to comment on two things from the Commission membership perspective. For example, on the option - your question mentioned the connector. The Commission members themselves, looking at the design of the Massachusetts system, came up with a fairly logical question. What would be the implications if what was being done with the connector in Massachusetts was turned into a national model? Is there way to estimate that? That was the motivation for taking a look at that.

In terms, Ms. Smith, of you getting to the feasibility question, what the Commission is try to look at is what some of the options are for bringing high performance to the system without having, if you will, the initial benchmark of political feasibility. I think the political feasibility issue, or, if you will, the fiscal and budgetary issue, is a consideration that we'll obviously have to deal with down the line, but we did not feel that we should basically take a whole lot of options off the table for analysis simply by saying that we'd consider no option requiring upfront investment. At that point, it wouldn't have allowed us to do what we're attempting to do.

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KAREN DAVIS, PH.D.: Other questions or comments? I think, with that, we're going to draw it to a close. Again, let me thank the panel and thank all of you for joining us.

[Applause]

[END RECORDING]