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**SUMMARY OF THE 2004 NATIONAL HEALTH POLICY
CONFERENCE**

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**Prepared by: Lori Achman
Glen Mays
Marsha Gold
of
Mathematica Policy Research, Inc.**

2004 NATIONAL HEALTH POLICY CONFERENCE

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BUSH ADMINISTRATION'S HEALTH POLICY AGENDA

A Webcast of the session and transcription is available at www.kaisernetwork.org.

Doug Badger, White House health policy advisor

Doug Badger began his statements by outlining President Bush's health care accomplishments over his first three years.

Badger stated that the Medicare prescription drug benefit is a historic accomplishment. He noted there was a great deal of skepticism that the legislation would pass. He also emphasized that having to pay for drugs has been a tremendous hardship for seniors, but that that will change as a result of the legislation. While the full benefit will take effect in 2006, seniors will begin seeing benefits sooner with prescription drug discount cards, which will take effect in 2004. The cards, he said, should provide seniors with 10 to 20 percent discounts off of the retail price of medications. According to Badger, there has been a surge of interest in organizations wishing to sponsor a discount card. More than 100 organizations have stated their intention to file an application with the Centers for Medicare and Medicaid Services (CMS). Final applications were due January 30, 2004.

The National Association of Chain Pharmacies is one of the organizations that will sponsor a card. They were actually the same organization that blocked the administration's initial attempt to implement a discount card. In addition to the drug card, seniors with incomes below 135 percent of the federal poverty level (FPL) will get an immediate \$600 in assistance to purchase prescription drugs in 2004, and then another \$600 in 2005.

In 2006, the full benefit will be implemented. Badger noted that low-income seniors will get even more help, paying just \$1-\$2 co-payments, and no more than 15 percent coinsurance. The bill, he said, provides the most help for poor individuals and high users of health services.

Badger also discussed the increased payments to health plans that were implemented this year as part of the legislation. Health plans received an average 10.6 percent increase in rates. He noted that all of that increase has to be passed on to seniors. Some health plans have already announced that they will re-enter areas they had withdrawn from, and others have announced premium reductions.

Another part of the Medicare prescription drug bill is the creation of Health Savings Accounts (HSAs). The bill lifts the restrictions that were a problem for Medical Savings Accounts, namely the time-limited demonstration aspect and the cap on enrollment. With HSAs, any individual in a high-deductible health insurance policy can use the HSA. The money in and out of HSAs is tax-free. Also, individuals can roll over their savings from year to year and earn interest and dividends. Badger said that 23 companies have already announced they are selling HSAs. He also said that an article in *USA Today* stated that the biggest problem has been that people haven't been able to find them.

In addition to the drug bill, from January 2001 to December 2003, the U.S. Department of Health and Human Services (HHS) has granted thousands of waivers and state plan amendments to

states that have resulted in an additional 2.6 million individuals becoming eligible for Medicaid and the State Children's Health Insurance Program (SCHIP).

The Bush administration has increased funding for Federally Qualified Health Centers (FQHCs). The goal is to have 1,200 new or expanded FQHCs by 2006. Badger said that having primary care available is an important safety net. The administration has closed loopholes in the Hatch-Waxman Act to help get generics to market faster, doubled funding for the National Institutes of Health, and increased funding for bioterrorism preparedness, according to Badger. In addition, the president just announced a Global AIDS initiative to provide public health to third-world countries.

Despite the accomplishments, Badger said there is still a lot of unfinished business. This includes:

- Association Health Plans;
- Refundable tax credits for the individual health insurance market worth up to \$1,000 per individual and \$3,000 per family;
- Reforming the medical malpractice system; and
- Providing more money for Information Technology. The President is proposing to double spending on Health Information Technology (HIT) to \$100 million. Also, in the new Medicare law, in order for hospitals to get the full, market-basket inflation adjustment, they must adopt specific quality standards, which includes electronic records.

Badger stated that the president's proposals on the uninsured reflect the complexity of the issue. He said that solving the problem will not come from a "one-size-fits-all" approach because the uninsured are such a diverse population. Consequently, the problem calls for targeted solutions that build on the existing system to expand coverage. Each proposal targets specific groups of the uninsured.

Badger concluded by saying that the president has "a record of accomplishment and a portfolio of ideas" on health care and is looking forward to the debate.

Tom Scully, former CMS administrator, now with Alston & Bird

Tom Scully stated that he is very proud of the Medicare Reform bill. He said that he disagrees with those who say the bill is not enough. It is the biggest change in Medicare for a long time. The primary goal is to help low-income seniors, which the bill does. Scully said that the bill is better than the catastrophic bill, and it won't be repealed because even the wealthiest senior is getting a 74.5 percent subsidy.

Scully said that his major concern with the bill is that it is too big. Co-payments for poor seniors are too low to provide an incentive for people to ration their health care.

Scully stated that AARP and Sen. Baucus have taken a lot of heat on the bill, but they did the right thing because it is a good piece of legislation. The only people who should be worried are

the Congressional Budget Office and the Office of Management and Budget because of the budget implications, he said.

On May 1, poor seniors are going to get a \$600 subsidy for prescription drugs in 2004. They will get another \$600 for 2005.

Scully said that the drug card is a “no brainer.” With the drug cards, seniors will pay 10 percent to 15 percent less for drugs. Scully believes the drug cards will lead to less re-importation of medications, because people will be paying less for their drugs in the United States.

In 2006, seniors will get a “monster benefit.” Individuals who earn incomes lower than 100 percent FPL will get a benefit worth \$4,100; those between 100 percent and 135 percent FPL will get a \$3,900 benefit. And seniors in the highest income levels will still get a \$1,400 benefit. He said that the benefit would make a big change in people’s lives.

Scully said that the legislation leaves no gaps in coverage for low-income beneficiaries.

The Medicare reform bill will also vastly improve the HMO benefit. Because of the legislation, companies will start returning to the market because the numbers will work a lot better, according to Scully. Plans will get money for their drug benefit, so the drug benefit will improve. He believes that market penetration in HMOs will go up to 17–18 percent.

He also thinks that people will choose to enroll in Medicare preferred provider organizations (PPOs) “in swarms.” He said that it will be more attractive for individuals to buy a community-rated integrated benefit package through a PPO rather than have traditional fee-for-service (FFS) Medicare, a Medigap plan, and a separate prescription drug plan. CMS actuaries estimate that 15 to 17 percent of the Medicare population will be in HMOs, and another 15 percent will be enrolled in the PPO products. While the bill allows seniors to stay in FFS if they want, Scully thinks people will want to move to PPOs.

Overall, Scully said the Medicare bill moves health care into a more commercial, negotiated payment system. Currently, just 35 percent of hospital payments come from commercial insurers, and 55 percent comes from Medicare and Medicaid payments. Medicare and Medicaid are price fixers. Under the bill, more of the share of payments will come from private insurers. There will be more negotiated payments. Private insurers will be able to push for outcome-based performance measures.

Scully also discussed the increased reimbursement rates for physicians and hospitals. In the next couple of months, he said, there won’t be a lot of change because of the bill. However, he warned that hospitals will need to be careful of putting themselves at risk of big payment cuts after the election if their margins start going up.

In terms of the pharmaceutical industry, Scully said one of the most criticized portions of the bill was the section that said that the U.S. Secretary of Health and Human Services cannot negotiate pharmaceutical prices. He said that the government never could negotiate rates because they would be fixing prices. According to Scully, the bill will break up the Medicare share of drugs into five-to-six pharmacy benefits managers (PBMs) that will negotiate prices. He said that the PBMs will be strong, and their transactions with the pharmaceutical industry will be transparent,

which will make a lot of the complaints against the PBM industry disappear. In the long run, drug companies will be better off because of the Medicare benefit. They will see lower margins, but higher volume. However, how the industry deals with PBMs will become more complicated.

Scully anticipated that CMS will garner a lot more attention because of the legislation, especially from pharmaceutical companies. The Center for Beneficiary Choices, which is now very small but already swamped, will need to hire more people, he said. Congress gave the agency \$1 billion to implement the legislation.

HSAs are intended to complement high-deductible policies in the health insurance market. In the past, the problem with high-deductible policies has been that individuals paid the under-deductible amounts with taxed dollars, and they paid charges rather than the insurance company's negotiated rates. HSAs will allow individuals to pay up to the deductible with tax-free dollars and to pay the insurer's rates rather than charges. Scully believes that HSAs will be positive because they will bring more people into private health plans.

According to Scully, the next big health policy priority is the uninsured and bringing equity into the under-65 market. He acknowledged, however, that it will be difficult to accomplish that without any money. In his response to a later question, Scully stated that the federal and state governments already spend about \$35 billion per year on the uninsured, and that health plans are also subsidizing the uninsured, probably another \$30–\$35 billion. If we could eliminate the subsidies and pool the money, we could cover the uninsured.

Regarding health care quality, Scully said that it is “crazy” that consumers do not have information on how well their providers perform and that providers are paid the same rate regardless of the quality they provide. He believes that public reporting would change behavior overnight.

With CMS's premier demonstration, there are 36 Diagnosis-Related Groups (DRGs) for which hospitals receive a 2 percent bonus if they are in the top 10 percent on quality and a 1 percent bonus, if they are in the top 20 percent.

During the question-and-answer period, Scully said that he hopes that the chronic care demonstrations that CMS is doing will work, although it is still an unknown whether disease management can save money. He said that there are those who say that the private sector has already pumped a lot of money into disease management and it hasn't made a lot of difference.

Mark McClellan, The Food and Drug Administration

Mark McClellan started by saying that 2003 was an important year during which we have seen a lot of improvements in medical technology. There are also more innovative applications at the FDA than at any time before. This century, he said, may be known as the biomedical century. Society is developing new responses to bioterrorism, infectious diseases, and diet.

One of the FDA's priorities is to make new technologies and medicines available to the public more quickly. However, right now there is concern that people have to trade off between safety and cost. The Medicare Modernization Act will increase the availability of generic medications to the market, he said.

McClellan said that it is easy to understand why individuals are going across the border to purchase medications at a lower cost. Americans today are paying for half of global pharmaceutical costs, which is more than our share of use represents. However, the FDA cannot endorse a buyer-beware philosophy to purchasing drugs. He said there are serious problems with Internet pharmacies and storefront pharmacies that cannot assure the safety of the medications they are selling. The FDA has built a strong drug safety system in the United States over the past decade. However, that system is under attack, according to McClellan, because there is money to be had and because technology has emerged that can create counterfeit products.

The FDA, in partnership with the Customs Bureau, performed a blitz in November at a number of border points to inspect pharmaceuticals that were being shipped into the country. There were many examples of drugs that were illegal, recalled, or counterfeit. Also, a number of the drugs seemed to be coming from Canada, but had actually originated from other countries.

Counterfeit drug investigations within the FDA have increased fourfold since the late 1990s. The FDA will soon be announcing the findings from a task force on counterfeit drugs.

McClellan also stated that it is not just the FDA against re-importation. Medical groups, pharmacy groups, and Canadian pharmacy groups have also issued statements against re-importation. The FDA is studying what additional authority and steps would be necessary to certify the safety of imported drugs.

In 2002, Congress passed legislation giving the FDA the ability to protect food imports. This has boosted food security in the United States. The legislation requires the FDA be notified of all food shipments. Also, for the highest risk foods (meats and poultry), resources must be provided so that the FDA can check the source of the food and inspect those plants.

The FDA is concerned about declaring additional sites as drug distribution sites without giving the agency the ability to monitor those sites.

The FDA is also studying the potential real savings from re-importation. McClellan said that the savings may not be as great as one would hope when you include the shipping costs, safety costs, and the fact that generics in the United States are cheaper than in other countries. He noted that the Commonwealth of Massachusetts recently did a study and noted that importing drugs from Canada would not save significant dollars. The CBO estimated that re-importation would offer less than 1 percent in savings.

There are better ways than re-importation to make prescription drugs affordable, according to McClellan. The best way is to substitute generics. He noted that 7–8 percent of Medicaid prescription drug budgets are spent on brand name drugs that have a generic alternative. Health plans have seen significant savings when they go to a generic substitution policy. Another way to keep drug costs down is to case manage high-cost patients. He also mentioned providing better information to consumers on different treatment options, and promoting the use of e-prescribing. McClellan stated that the Medicare Modernization Act improves the standards for e-prescribing. He said that the Act also increases the payoff for providers who use health information technology.

McClellan said it is a global issue to decrease the share of prescription drug costs that the United States pays for. He added that he doesn't necessarily mean that other countries need to increase their prescription drug spending, but they can change the way their dollars are spent. For example, other countries should to allow more competition for generics in their markets. He noted that generics are more expensive in other countries than in the United States. Other countries are already allowing more generics in their markets for drugs that fight certain diseases, such as AIDS and malaria. He also said that controls are needed so that low-price drugs are targeted to needy developing countries.

In order to speed up the time that FDA approvals take, the FDA is working with organizations that apply for approvals to help them get their research and development done right the first time. They are also providing better guidance on requirements to product developers.

McClellan also noted that there needs to be improvements in manufacturing processes that will increase quality. These solutions are cost-reducing and precision-enhancing, much like the transitions that the computer sector has already made.

MEDICARE AND PRESCRIPTION DRUGS

Robert Reischauer, The Urban Institute

Robert Reischauer provided an overview of the decisions that beneficiaries and employers will confront as a result of the Medicare prescription drug legislation. He stated that the legislation is incredibly complicated, and will change the way that both retirees and the under-65 population purchase health insurance.

There are four basic decisions that employers who already provide retiree prescription drugs will have to confront:

1. Which Option to Choose? Should they accept the 28 percent government subsidy to keep offering drug coverage (for per person expenditures of \$250–\$5,000), or become a closed prescription drug plan (PDP) as described in the law, or drop coverage altogether?
2. For those who keep coverage, should they modify the benefit design? For instance, in order to maximize the government subsidy, to take advantage of the catastrophic benefit, or to share the subsidy with their retirees.
3. If employers decide to become a closed-panel PDP or to drop the benefit, they will likely be reducing coverage under what they currently offer. Do they want to provide any other incentives for their employees, such as paying an employee's PDP premium, paying more of the premium for non-drug retiree coverage, reducing the non-drug cost-sharing for employees, or increasing employees' cash pension benefits?
4. Should the employer change their current employee options in order to take advantage of the Health Savings Accounts (HSAs)?

These decisions will affect the distribution of costs between employees and retirees, workers and employers, and high- and low-cost users.

Beneficiaries also face a number of decisions because of the new law, including:

1. Should they purchase a drug card?
2. Which company's drug card should they purchase? This will depend on whether the individual beneficiary's current drugs are on the formulary, the depth of the discounts offered, the breadth of the formulary and the average discount for drugs that aren't used chronically, the breadth of the pharmacy network, and the membership fee.
3. Should they apply for the low-income subsidy? It has been said that, because there is no asset test, it should be easy, but this is still not totally clear.

4. Should they participate in the full PDP in 2006? The decision will need to be based on:
 - a. The individual's expected drug expenditures now and in the future;
 - b. The types of plans that are available (stand-alone PDPs, fallback plans, local Medicare Advantage HMOs, Regional PPOs, or national PDPs);
 - c. The formularies, premiums, and cost sharing of the available plans. Plans will have a lot of latitude in how they modify the standard plan in the law; and
 - d. Late enrollment penalties. The penalty will be at least a 1 percent addition to the individual's premium for the rest of his or her life for each month that he or she goes without enrolling.

5. Should they apply for the low-income program in 2006? There will be an asset test in 2006 and a lot of seniors have no experience with the welfare system.

An important issue in the coming months will be who will provide the information for beneficiaries to sort through and how good that information will be. Potential educators include the Centers for Medicare and Medicaid Services, advocates for seniors, the media, and providers.

Robert Galvin, General Electric

Robert Galvin discussed what employers think about the Medicare prescription drug law. He said that, overall, employers like the bill. They are positive but cautious because a lot of the details are yet to be operationalized. Also, employers are excited that the bill offers a lot of opportunities to improve health care quality.

Galvin stated that the bill isn't perfect, but it was passable. Employers saw the bill as a sign that the government can act on health care and include employers in the dialogue. Employers generally like the competitive market approach in the law and believe that it will result in greater transparency.

Despite the fact that the bill has passed, Galvin said that "we are only halfway there." Details still need to be worked out on how the actuarial equivalency will work. Also, employers are awaiting guidance from the government on the implications for the Financial Accounting Standards Board. With HSAs, employers like the idea, but Galvin said it will be a challenge to have a fixed deductible plan with an out-of-pocket maximum that isn't tiered by salary. In addition, employers are still awaiting the rules for pharmacy benefits managers (PBMs) and health plans.

Galvin participates in the Leapfrog Group. He said that Leapfrog employers like the fact that the bill will provide more opportunities to look at quality in addition to payment. The Leapfrog Group is working to get providers to do better on quality and efficiency. He said quality information needs to be available to the consumer.

Currently, he said, data on the quality of hospitals and other providers is collected, but that information is not shared. In a lot of cases, purchasers can actually enjoy cost savings by choosing providers who have the best quality over those who have the worst.

The Washington Business Group on Health has said that there is a lot more leverage in terms of cost savings to be gained from purchasing according to quality/effectiveness (25 percent) vs. implementing more competition (1–2 percent).

Overall, Galvin said that the Medicare legislation gave employers a better appreciation that government and business are “in this together.” He said that there must be a realization that what is in the system is key to how many people get into the system.

John Rother, AARP

John Rother presented information on the implications of the prescription drug legislation for consumers. He stated that the bottom line is that the legislation moved us halfway there. Despite AARP’s support of the legislation, there remains a lot on the agenda for the year ahead, including cost containment, the benefit gap, and the complexity of the legislation.

Rother began by discussing the need for prescription drug coverage. He said that today’s prescription drugs do more than just mitigate systems; they control chronic conditions and protect against acute episodes.

Rother presented some information about the distribution of prescription drug expenditures among the elderly. About 10 percent of seniors have no prescription drug spending. Another quarter of seniors have less than \$1,000 in annual prescription drug costs. Thirty percent have costs between \$1,000 and \$3,000. Five percent of seniors have more than \$10,000 in prescription drug expenditures.

The danger with the legislation, he said, is that low-risk individuals may not feel compelled to enroll. It will be important to convince low-risk individuals that it is important for their future to enroll. Rother said that people tend to look at their current drug spending, and that that approach can be shortsighted. The bill attempts to incentivize people with the 1 percent per month penalty for late enrollment. He said that the government and senior advocates will need to convince people that this is an insurance program, not just a benefit program.

The impact of the legislation will vary according to beneficiaries’ spending, said Rother. Everyone except those with very low spending will gain from the benefit, and the benefit increases as expenses increase.

One of the problems with the prescription drug benefit is that the standard benefit design does not make sense to beneficiaries. Beneficiaries do not understand the rationale of the design. Private plans will try hard to not offer the standard design, but instead a plan without a donut hole.

There are four categories of low-income seniors who will be helped to a varying extent by the low-income provisions in the law: dual eligibles earning under 100 percent of the federal poverty level (FPL); those earning 101–135 percent FPL who are under the asset limit; individuals with incomes between 101 and 135 percent FPL who are over the asset limit; and those at 135–150 percent FPL. Rother called the bill a huge social achievement. However, all states will have to re-design their Medicaid and prescription drug assistance programs, he said, and dual-eligibles could also face higher costs than they currently face under Medicaid.

AARP is advocating that the asset test be removed. Rother stated that AARP thinks that the asset test is incompatible with the goal of helping low-income individuals. It will disqualify 10 percent of seniors who would be eligible for low-income assistance without the test, and it will create an administrative problem for states, he said. The asset test will also scare people away from applying even if they are eligible.

Rother said that he thinks the immediate help through the \$600 subsidy will be very popular. AARP and others are going to be launching a consumer education campaign in the spring. The pharmaceutical companies have already announced that they will continue to offer their discount programs and will allow individuals with the subsidy to use the \$600 toward their drugs.

When the benefit is up and running in 2006, individuals will have to make choices about their benefit design. Plans will offer different designs even though they will have the same actuarial value.

Another good point of the bill is that it includes structural change to the Medicare program. The legislation adds a chronic care management component and new preventive benefits. It also requires electronic prescribing for doctors and pharmacies, which will improve quality. The bill transforms Medicare from a bill payer into a health care program.

The bill protects retirees who already have prescription drug coverage, Rother said. There is \$71 billion in direct subsidies, tax-free, for employers who offer retirees prescription drug coverage equivalent to the basic Medicare benefit. Congress realized that keeping people in employer-sponsored coverage saves Medicare money.

As to the effect of the legislation on employers, Rother said that a typical employer will retain benefits for their current retirees and workers, but probably limit their coverage for future employees.

The major points, which AARP will continue to advocate for, is a better and more generous benefit design and more provisions in the law to keep pharmaceutical costs down. AARP would like to see Congress legalize re-importation and give the HHS Secretary negotiating power on pharmaceutical prices. Regarding the benefit design, AARP wants to close the donut hole and eliminate the asset test for low-income seniors. In addition, the group wants to see better coordination with state pharmacy assistance programs and allowance of the possibility that a state may want to offer a prescription drug plan. The group also has some concerns about the design of the fallback plans.

There are some points that AARP will closely monitor. The group wants to see if health plans will re-enter the Medicare market, if plans will cherry pick the healthiest beneficiaries, and how aggressive plans will be with their formularies. They also want to examine whether beneficiaries will understand the complexity of the choices, or whether the complexity will lead to paralysis on the part of beneficiaries.

During questions, Rother was asked about how much education AARP will be able to do considering that every state's circumstance will be different. He responded that all states will need to re-design their programs. He admitted that AARP will be handicapped somewhat in that

they have traditionally used national communication efforts, but that those efforts alone won't be sufficient under the new system. AARP will partner with other local organizations to get information out. Rother added that the additional \$1 billion allocated to CMS to implement the legislation includes beneficiary education. AARP is advocating for Congress to increase that amount because the current allocation is inadequate. Rother noted that complexity is an inevitable byproduct of bipartisan policymaking.

When asked about the possibility of a technical corrections bill, Rother stated that Congress and the president will probably resist any technical corrections bill until after the November elections. There are some legitimate issues where there is agreement that something needs to be fixed. However, they will probably be left until after the elections.

USING INFORMATION TECHNOLOGY TO MANAGE CARE

Daniel Mendelson, The Health Strategies Consultancy

Daniel Mendelson served as the breakout moderator and provided an opening presentation focused on health information technology (HIT) to put the session into context. He stated that reimbursement is the key driver for information technology and that improvements in reimbursement systems were necessary in order to make real progress.

Private-sector models of implementing HIT are proliferating. However, one of the impediments to more implementation is that proof statements are lacking from a return-on-investment perspective.

Mendelson noted that 2003 was a good year for HIT in the United States. Although this country allocated \$100 million for health information technology, the United States is significantly behind other countries. For example, the United Kingdom has allocated \$17 billion for health information technology. Mendelson stated that good public models of HIT will guide the future of the technology.

Mendelson stated that there are five possible types of payment systems for health information technology:

1. Payment differentials: Rewarding providers who use information technology;
2. Consumer differentials: Giving consumers bonuses and incentives to use providers who use information technology;
3. Innovative reimbursement: Developing new categories of care reimbursement related to health information technology (i.e., a specific payment for e-mail communication with a patient);
4. Shared risk: Withholding fees or delaying payment increases until the adoption of IT. There's not a lot of activity on this front.
5. Combined programs: Using more than one of the above methods.

There have been multiple experiments with different payment mechanisms, but it is too early for any evaluation results.

Within the Medicare Modernization Act, there were numerous provisions related to HIT. Some of the provisions were:

- Call for e-prescribing (although it stopped short of a mandate);
- Management performance demonstrations;
- The establishment of a commission on systemic interoperability;
- Establishment of the Council for Technology and Innovation;

- An extension of the telemedicine demonstrations;
- Some demonstrations related to chronic care improvement.

There are a number of federal agencies that have grant programs for information technology, including the Agency for Healthcare Research and Quality (AHRQ), the Health Resources and Services Administration (HRSA), and the Centers for Medicare & Medicaid Services (CMS), and AHRQ in partnership with the Veterans Administration and/or the National Institutes of Health. Medicaid also provides states with a 90 percent federal match for information technology upgrades.

Mendelson concluded by saying that HIT will not be implemented in the next couple of years. Currently, there is little dedicated budget for HJT compared to other countries and the pluralistic health insurance system in the United States skews alignment.

Helen Burstin, The Agency for Healthcare Research and Quality (AHRQ)

Helen Burstin's presentation aimed to put HIT in the context of patient safety and quality. She noted that the recent RAND study found that quality in health care is not optimal much of the time. There are also significant public concerns about medical errors. A recent survey found that 47 percent of the public were "very concerned" about medical errors when they go into the doctor or hospital. Six percent have experienced a personal injury or harm because of a medical error. The Institute of Medicine report on quality stated that information technology is necessary to reduce medical errors in the system.

Burstin stated that there already is a good amount of literature on how HIT significantly increases quality of care. It also leads to a better exchange of health care information. There is also potential for information technology to improve quality assessments and measurements and to enhance the transition to the adoption of better quality measures.

Adopting information technology will be a challenge due to the absence of a clear return on investment. Burstin mentioned that we still don't know the full opportunity costs in terms of provider time or how to incentivize adoption.

If electronic prescribing were to be fully implemented in the ambulatory environment, it would eliminate more than two million adverse drug events per year nationwide. The makers of one of the electronic prescribing tools, E-Pocrates, surveyed the physicians who used the tool, and found that 50 percent of them said the tool prevented one-to-two adverse drug events per week.

The federal government has undertaken a number of activities related to HIT:

- The Council on the Application of Health Information Technology (CAHIT): This is an internal coordinating and advisory council at the Department of Health and Human Services to promote the exchange of information on HIT;
- National Health Information Infrastructure (NHII): There are already a series of stakeholder meetings, and the government is doing a study on organizational issues;
- CMS Pay for Performance Demonstrations; and

- FDA is piloting automated adverse event reporting.

With its emphasis on patient safety, AHRQ is taking a lead on HIT. In 2004, \$60 million is in AHRQ's budget for HIT contracts and grants, \$26 million of which is designated for small and rural communities, \$24 million is for new and innovative forms of HIT for patients, and \$10 million is for the development of clinical data standards. AHRQ, Burstin said, has focused on the idea of community partnerships.

Burstin concluded by saying that clinical practice hasn't changed much since the days of Marcus Welby. She noted that 60 percent of doctors are in practices with six or fewer doctors, and that it is difficult to have a wide dispersion of technology in such small environments.

Regina Groves, Medtronic, Inc.

Regina Groves discussed her company's experience with its Carelink Network.

There are currently 100,000 patients in the United States with implantable electronic cardiodefibrillators. Each time one of the implantable defibrillators is put in, the burden on the health care setting grows because each implant needs to be checked four times per year. Groves' company saw a growing crisis in terms of the amount of visits to offices as a result of the technology.

In response to this trend, Medtronic designed the Carelink network, which allows patients with the implants to get the device checked over the phone. Patients set up a time with the clinic, and, while on the phone, they hold an antenna that is part of the Carelink kit over their chest. The information is downloaded to the physician's office over the phone line. The individual can transmit the information from any phone line. Once the data have been submitted, physicians can log in and call up all of the results from the check over the Internet for all of their patients.

Groves said that the system enables better, more convenient, more efficient treatment for the patient. An office check of a device typically takes 20 to 30 minutes of clinic time. With Carelink, a check takes as little as 10–15 minutes of clinic time. The clinic can also batch all patients who are in the network.

The biggest obstacle, according to Groves, has been reimbursement. Medtronic has gotten Medicare reimbursement rates equal to a regular office visit at a clinic in 43 states. Some use an existing Medicare code, in other states they use a miscellaneous code. The company has also filed for a global code from Medicare.

Currently, more than 5,000 patients are in the Carelink Network. Groves said that the Veterans Administration has been an early adopter. Five hundred VA patients in 22 clinics nationwide use the Network. Other VA sites are in the queue to implement the network.

Clinics of all sizes have used the Network, Groves said. However, for clinics to begin seeing any efficiency from the system, it usually takes 50–100 patients to be enrolled per site.

She concluded by saying that Medtronic believes the system will facilitate better care collaboration across caregivers and ultimately optimize health care resources.

William McIvor, Accordant Health Services

William McIvor provided an overview of Accordant Health Services. Founded in 1995, Accordant now provides disease management services to 40,000 sponsored members, from 19 customers that together represent about 30 million covered lives. Accordant focuses their disease management activities on 15 complex disease states, including lupus, multiple sclerosis, and seizure disorders. They do not target the typical diseases that other disease management programs address, such as diabetes.

McIvor presented data that showed that, as people's length of time in the program increases, their per member per month expenditures decrease. He showed that average per member per month expenditures decreased from nearly \$800 in an individual's first quarter in the program, to about \$300 by their eighth quarter.

Accordant's disease management program is built on a system where nurses respond to patients over the telephone, providing needed information and advice. Nurses are able to respond to patients based on an information system with branching logic. Therefore, if an individual has multiple sclerosis, and reports symptom X, the system will immediately bring up information to answer that patient's questions. Accordant's system also generates automatic letters to physicians to notify him or her of any problems or concerns about patients. Using the information system, nurses can manage about 500 patients.

According to McIvor, the company has seen a decrease in the number of flare-ups for multiple sclerosis patients in their program.

McIvor said that technology is the key that allows his company to function. Technology allows them to streamline their call center operations, for instance, through skills-based routing of calls. This enables callers to more immediately speak with a nurse with specialized experience on a certain diagnosis. They have also developed a single PC-based interface that combines phone, fax, e-mail, and Internet communications.

Accordant is moving toward developing a more patient-empowered system, which would allow patients to do a lot of their own self-management over customized Web sites. It would also allow patients to control more how much interaction they have with nurses above and beyond the minimum frequency.

BIOTERRORISM PREPAREDNESS: LINKING THE MEDICAL CARE AND PUBLIC HEALTH SYSTEMS

John Lumpkin, The Robert Wood Johnson Foundation

Lumpkin provided an overview of the ways in which the medical care and public health systems interact in responding to both routine and emergency health issues. He noted that governmental public health agencies have long been responsible for performing regulatory and oversight roles for the health care system at large, including reviewing and assuring the quality and safety of health care facilities and professionals. The public health and medical care systems also interface in identifying and responding to diseases and other health threats on a population-wide basis. A clear example is reportable disease surveillance systems that rely on physicians, hospitals, and clinical laboratories to report cases of communicable disease to public health authorities so that the transmission paths can be traced and interrupted.

In the wake of 9/11, preparedness for bioterrorism and other public health emergencies has emerged as another area where the public health and medical care systems must interact effectively. Preparedness requires clear channels of communication and information-sharing among public health professionals, medical care providers, and other first responders; a rational division of responsibility and authority among these actors; and a feasible and well-rehearsed plan of action to coordinate the activities of these actors. The remaining speakers in this panel offered examples of strategies and tools for achieving these goals.

Virginia Cain, Marion County Health Department and American Public Health Association

Virginia Cain shared lessons from Indianapolis' recent efforts to develop a coordinated, community-wide process for preparing for and responding to bioterrorism. She stressed the importance of recognizing that a local public health system is more than just what local health departments do. A public health system includes the full range of organizations and professionals that contribute to public health within a community—including medical care providers, emergency response providers, community organizations, schools, veterinary clinics, and public utilities. Bringing these diverse players together to develop a coordinated plan for bioterrorism is a daunting task.

The mayor in Indianapolis helped the process by providing leadership. The process included participation by the state health agency, area hospitals, communications and media organizations, mental health providers, the legal community, emergency response providers, and private clinical laboratories. The planning process focused on agreeing on roles and responsibilities, opening lines of communication, and identifying relevant data systems and ways of sharing this information.

The process gave attention to special populations who present unique challenges in the event of bioterrorism or other public health emergencies, including non-English speaking populations, the homeless, home-bound and institutionalized populations, and undocumented immigrants. The planning process was first put into use to decide which segments of the health care workforce should be vaccinated for influenza and smallpox. The process was subsequently used to develop a planned response to Severe Acute Respiratory Syndrome.

A notable feature of the Indianapolis bioterrorism preparedness initiative is its information system, known as the Indianapolis Health Information Network. The participants have developed an integrated, community-wide information system that includes electronic data from laboratory reports and notifiable disease reports from area hospitals, all of which are transmitted to the local health department in real time to support case identification, follow-up, and control. The system also has the ability to support clinical messaging, immunization registries, Web surveys of health care providers, and disease management information and communication.

All of the area hospitals are on the network, and plans are under development for extending the network to community physicians and developing a regional information network that extends to neighboring communities beyond Indianapolis. Through other information systems, the bioterrorism preparedness initiative has access to information on over-the-counter pharmacy sales at a large drug store chain, information on 911 calls to the emergency response system, and information on hospital admissions. The initiative also conducts active surveillance through periodic calls to hospital emergency rooms and to sentinel urgent care centers around the community.

Richard Platt, Harvard Pilgrim Health Care

Richard Platt described experiences with the Syndromic Surveillance Demonstration Project, an initiative that brings together multiple health plans, providers, and public health agencies to test the feasibility and value of using health plan information to rapidly detect emerging health threats in the community. Patient-level information on symptomology is gleaned from physician office visits and calls to nurse triage centers and compiled in a centralized reporting system daily. Approximately 20 million people in 50 states are covered by the system through the health plans in which they are enrolled. A grouper methodology developed by the Centers for Disease Control and Prevention is used to classify cases into defined syndromic categories, and these cases are then mapped to the patient's zip code of residence. A methodology is then used to identify geographic areas experiencing unusually high rates of symptom occurrence, and the public health authorities in those areas are notified to conduct follow-up investigations.

Critical elements that allow the project to be feasible include:

1. All of the participating health plans use electronic medical records that provide access to patient-level clinical information in near real time;
2. Health plans report only de-identified counts of new episodes in each zip code to the project's centralized database in order to avoid concerns about disclosure of confidential patient data or proprietary information;
3. The project uses automated signal detection and alerting processes (including notification via pager and e-mail) that run on a daily basis, thereby minimizing the need for human oversight;
4. Public health authorities can obtain access to full patient-level data from the health plans if a "signal" or geographic cluster of symptoms is detected, in order to conduct follow-up investigations; and
5. The project requires no additional work on the part of health care providers since all information is gleaned from electronic medical records, with health plans running the automatic extracting routine nightly.

The project has so far proven to be feasible, but studies of its effectiveness, cost-effectiveness, and value are still under way. Preliminary analyses suggest the system would have allowed early detection of an influenza outbreak before laboratory results of influenza isolates were available to confirm the outbreak, as well as early detection of an *E coli* outbreak. More information on the project can be found at www.btsurveillance.org.

CONSEQUENCES OF UNINSURANCE

A Webcast and transcript of this session are available at www.kaisernetwork.org.

Jack Ebeler, The Alliance of Community Health Plans

Jack Ebeler began by noting that his job was to describe the first of five recent Institute of Medicine (IOM) reports as background for the panel's focus on the sixth and final IOM report on the consequences of uninsurance, which was just released. The context for the IOM's work and its impetus stemmed from concerns generated by public opinion research in the late 1990s. The research showed that an increasing percentage of Americans believed that the uninsured get the care they need. The question became, "Is that what the research shows?" and even if it is, "How does one make the claim for public action if the public doesn't believe it?" So the IOM's task was to consolidate the evidence relevant to the question of uninsurance, and to raise awareness of the research findings. While the IOM didn't address all the issues driving uninsurance, its six volumes cover a lot of ground.

The six reports include:

- *Coverage Matters*: This report provided an overview of insurance coverage, including the characteristics of individuals with and without coverage, etc.
- *Care Without Coverage*: This report focused on the health impacts of coverage and found that those without coverage got too little care too late and that continuity of care matters.
- *Family Issues*: This report focused on the family effects of coverage including the effects on care that might stem from one member of a family having coverage (e.g., a child) and another not (an uninsured adult).
- *Shared Destiny*: This report focused on community impacts of coverage including the effects of lack of coverage on health care institutions and providers.
- *Hidden Costs*: This report focused on the effects that lack of coverage has on the economy concluding that economic losses are substantial.
- *Call to Action*: This sixth report on recommendations was the focus for the panel.

Shoshanna Sofaer, Baruch College

The subcommittee that produced the sixth report was chaired by Sofaer and included chairs of the subcommittees that had been responsible for the prior five reports. Sofaer focused her task on how the report was developed, the lessons from history that it relied on, key recommendations, and the five principles it proposed to guide assessing solutions.

In terms of report development, Sofaer said that the committee made a number of key decisions, including the following:

1. They would not recommend specific detailed solutions;

2. They would provide evidence-based principles to assess proposals to expand coverage, and;
3. They would test these principles on some prototype proposals that Jack Meyer had developed.

Deciding not to develop a specific proposal was hard because everyone knows that the devil is in the details. However, history also suggests that this nation doesn't respond well to details and that reform involves political as well as policy analysis to identify approaches.

Ultimately, the subcommittee rejected the concept of incremental solutions based on an ongoing dialogue with the full committee. They were guided by a review of history suggesting that incremental solutions won't work to generate universal coverage as witnessed by the growth in those without coverage. This occurred even as Congress mounted a number of efforts to expand coverage and policies like the Employee Retirement Income Security Act, which limited state-specific solutions. The subcommittee noted that federal dollars were important to addressing this problem, but that federal dollars alone might not necessarily be called on to resolve it. The subcommittee also wanted to respond to the sense of urgency about this issue by setting a date by which they would like the United States to have achieved universal coverage—2010.

The vision they laid out was to promote better overall health through financial access for everyone nationally. This means coverage should meet the following criteria:

1. It should be universal, meaning that everyone must be an essential part;
2. It should be continuous;
3. It should be affordable to individuals and families (though cost sharing could be involved);
4. It should be affordable and sustainable to society; and
5. It should promote high quality that meets the six aims set out in the quality chasm report.

The committee used this work to assess a few stylized proposals for coverage involving different mixes of public versus private program, and group versus individual insurance models. They concluded that any of the proposals they examined would be better than the status quo, with some doing better on certain criteria and others on different ones. In reality, they expect that the ideal approach will be a hybrid. While the IOM did not cost out the prototypes, an analysis of the proposals on which the IOM prototypes were based showed that none of them were likely to bankrupt the nation.

Charles “Chip” Kahn, Federation of American Hospitals

Chip Kahn noted that he was speaking as an individual, not for his organization. He said that he had four main points to make in response to the IOM recommendations. First, he thought it would take great change to bring about the kind of universality that was in the recommendation.

Second, as long as there remains the kind of splits in Congress over strategies for expanding coverage that currently exist, it is difficult to envision that universality will be possible. He said that he's an incrementalist and proud of it.

Third, future coverage will take action at the federal level, but that requires money.

And finally, the idea of a 2010 goal is great but it is most important to expand coverage to those who lack enfranchisement to purchase reasonable coverage. He thinks it is more realistic to simplify by focusing on this group—finding them and covering them—and he thinks that is where it will start and end.

Kahn also commented on what he saw as the realities that policymakers must face over the next year and a half in order to actually do something about coverage. There is no free lunch. While it may be true there are dollars floating around somewhere in the health system, in reality the federal government will have to pay some or all of the cost of doing this. And, even if consensus is reached on funding, the question is how to deliver coverage. We are a 49 percent nation, with the two sides having very different views on how the system should go.

In terms of legislation, Kahn contrasted the legislative models behind the Balanced Budget Act and the Health Insurance Portability and Accountability Act (HIPAA) versus the Medicare Modernization Act (MMA). The former he saw as real progressive, by using the State Children's Health Insurance Program to expand coverage, with a consensus. Under the Medicare legislation, Congress did not use a consensus approach but rather a "thread the needle" approach. The problem with this strategy is that it needs a peculiar coalition to pass it and the task of getting that coalition can lead to political alienation. The things that allowed Medicare reform to pass will be hard to replicate as both conservative Republicans and the left in the Senate "got the joke" and are unlikely to play along in the future.

Kahn commented on what he thought it would take to get action in the short run. He said that perhaps out of the election this year there could be a mandate that resulted in some deals in 2005. There would also need to be a new formula on how to deliver coverage that would be acceptable (assuming money was available). Then the idea would be to move forward on action that builds on the current system.

Ron Pollack, Families USA

Ron Pollack began by citing the New Hampshire exit polls showing health care to be a very important issue motivating people. However, it is not clear how much the concern is Medicare, health care quality, or the uninsured. Pollack saw the IOM reports, even more than their policy recommendations, to be incredibly useful in documenting the long way we need to go in terms of coverage and the consequences of lack of coverage for the uninsured and spillover to society. While he did not want to undermine their recommendations, he urged caution in terms of the political context. He doesn't see a lot of room for creating the "right solution" versus political will to act.

Pollack highlighted a number of problem areas related to reaching universality. First, right now support for addressing coverage is based on the idea of altruism. He thinks support must instead become based on self-interest on the part of the public who feel a change is needed because a large a share of the U.S. population could be affected. Second, while polls show overwhelming support for the universal concept, that support is a mile wide and an inch thick because it relies on altruism. Third, there is no consensus on approaches to translating support into action. People are divided on solutions and they feel strongly about their respective positions. He urged caution in interpreting the IOM recommendations as a sign that solutions need to be universal or nothing. He sees incrementalism as okay in that it can lead to sequentialism.

He urged policymakers not to reject proposals because they don't get us all the way to universal coverage. Fourth, he noted that this is a precarious time fiscally, with enormous deficit projections and state budget problems too, and with public health on the chopping block. He urged that universality be looked at soberly because it was unlikely that one approach could win by clobbering others

Pollack closed with something more optimistic and uplifting, noting that he saw some signs that we will have real change. Interest in the uninsured is so high that he said even the president has to talk about it, if for no other reason than to inoculate himself. Also, while recent growth in the number of uninsured is troubling, the positive is that it expanded the share of families feeling it personally and could shift the focus from altruism to self-interest ("lemons out of lemonade"). Also, in the past everyone's second best solution was to do nothing. He found it encouraging that gradually more and more interest groups are saying that they can't accept that as a second-best solution to their favorite.

In the discussion that followed one person asked if we can sell expansion as a way to ultimately cut costs, but Pollack indicated that he was concerned that such a focus ultimately will force the issue away from a discussion of the uninsured. In any case, it was not clear that reductions would be specific to the people paying the bill.

HEALTH AS FOREIGN POLICY: HOW DOES GLOBAL HEALTH FIT INTO THE DOMESTIC AGENDA?

Jeffrey Sachs, The Earth Institute, Columbia University

Sachs began his comments on global health issues by examining the challenges presented by U.S. pharmaceutical policy. He noted that current patent laws intentionally create a gap between drug prices and the costs of drug production in order to encourage continued product innovation in the pharmaceutical industry. As a result, drug prices are many times higher than drug costs, resulting in underuse of medications by people who cannot afford them. Sachs argued that the temporary monopolies created by pharmaceutical patents introduce large inefficiencies into the market for pharmaceutical products by preventing price competition and encouraging manufacturers to spend heavily on marketing and distribution activities in order to raise demand for their products during the patent protection period.

As an alternative to the current patent protection system, Sachs called for greater governmental funding of the drug development process—particularly funding for clinical trials and not just basic research. By lowering the development costs borne by manufacturers, government can ensure that adequate incentives exist for product innovation without having to extend patent protection and monopoly profits to manufacturers. Sachs argued that this approach would reduce the price of drugs, eliminate much of the gaming that occurs in drug pricing internationally, and thereby reduce the need for drug re-importation.

Sachs continued by describing the enormous human toll that preventable and treatable diseases exact in Africa due to the lack of access to medications and other basic health interventions. Each day this disease burden includes approximately 8,000 people who die from malaria, 8,000 deaths due to AIDS, and 4,000 deaths due to tuberculosis. Only a few hundred of the six million individuals in Africa with late-stage AIDS are receiving antiretroviral drug treatment. Despite this large burden, there has been no comprehensive study of the feasibility and cost of undertaking a comprehensive disease control program in Africa for malaria, tuberculosis, or HIV/AIDS. Sachs argued that there has been little recognition in the United States or other industrialized nations of the social, political, and economic benefits to be gained from solving these global health programs in Africa and other developing regions.

The World Health Organization (WHO) recently chartered a commission to study the issues of global macroeconomics and health and to begin to identify strategies and goals for health improvement. As a member of this commission, Sachs noted its key findings:

- Millions die annually from a relatively small collection of conditions including AIDS, tuberculosis, malaria, diarrhea, acute respiratory infections, vaccine-preventable diseases, parasitic diseases, and child-birth (lack of emergency obstetrical care).
- All of these conditions have known available technologies for treatment and prevention that simply do not reach poor people.
- The very poor are simply too poor to stay alive on their own means. These situations are not precipitated by corrupt governments or bad decisions about resource allocation in developing nations, but rather by poverty.

- The industrialized world could save millions of lives per year in poor countries with a relatively modest commitment of resources. Providing basic health services to all of sub-Saharan Africa would cost approximately \$25 billion per year, or about \$25 per person per year in the industrialized world. This cost is a very small amount of the \$25 trillion economy that exists in the industrialized world.

Sachs lamented the fact that the U.S. government has yet to respond to the WHO's findings and recommendations on these issues. He warned that the costs of ignoring these global health problems are considerable. If we do not value human life in these countries, we put our own lives at risk in the form of national security problems. Further, left unchecked, these countries will remain reservoirs of known diseases and breeding grounds for emerging diseases that lead to the rapid global transmission of disease. By failing to help developing nations overcome their disease burdens, we will forgo the benefits of global economic development via expanding markets for our products and services. Finally, if persistently high disease burdens prevent developing countries from achieving a demographic and economic transition (e.g., to lower fertility rates), we will continue to suffer global environmental degradation.

IMPROVING HEALTH CARE FOR VETERANS

C. Ross Anthony, RAND

This session was designed to look at the progress of the President's Task Force to Improve Health Care for Our Nation's Veterans (PTF). The PTF was created to improve the coordination between the Veterans Health Administration (VHA) and the Department of Defense's (DoD) military health system. Specific goals included looking for ways to improve care, reviewing barriers to coordination, and identifying opportunities for better resource allocation. The 15-member panel came up with 22 recommendations in four broad areas.

According to Anthony, part of the problem with coordinating the health systems of the Department of Veterans Affairs (VA) and DoD has been their different missions. The DoD provides health care to active military and runs an insurance program for retirees and dependents. The VA's historic mission has been to care for veterans with service-connected impairments and indigent veterans. Their population is poorer, sicker, and older.

Examples of the recommendations were:

- VA and DoD should develop inter-department electronic records.
- There should be better tracking of exposure among the troops.
- There should be full funding of veterans in categories 1–7 within the VA.

The recommendations emphasized accountability, tracking, and reporting.

The Hon. William Winkenwerder, Jr., Department of Defense

Winkenwerder provided an overview of the military health care system. In total, the military health system serves 8.9 million beneficiaries; about 4.2 million are enrolled in TRICARE Prime, the military's HMO-like program. Total expenditures for health care are about \$28.3 billion. The military health system includes 75 military hospitals, 461 clinics, and 131,065 personnel (about 90,000 in uniform). In addition, TRICARE has relationships with support contractors who are responsible for purchasing care, including TriWest, Humana, and Health Net. The military also administers a single prescription drug benefit.

One of the main missions of the military health system is to provide battlefield medicine. The military aims to provide a continuum of health care wherever an individual service member is assigned. Medical assets are configured to support health promotion, hazard assessment, countermeasures, and rapid evacuation. During Operation Iraqi Freedom, 4 percent of the active troops came in each week for medical care—the lowest number in battlefield history. Just 1.5 percent of individuals who were wounded died.

Winkenwerder then reviewed some of the key accomplishments of the DoD/VA collaboration.

The DoD/VA have established a Joint Council Structure. The Joint Executive Council oversees both a Health Executive Council and a Benefits Executive Council. The Health Executive Council provides leadership oversight to all health care policies and procedures. The council is in charge of implementing and further developing the Joint Strategic Plan. The Benefits Council is working on opportunities to expand and enhance information sharing. The Benefits Council is also in charge of identifying procedures to improve the benefits claims process. The goal of the Benefits Council is to make a seamless transition from active to veteran status.

The Joint Strategic Plan was approved in April 2003. The plan is intended to improve the quality, efficiency, and effectiveness of the delivery of benefits to active military, their families, veterans and retirees through an enhanced partnership between the DoD and VA.

There are six strategic goals within the Joint Strategic Plan:

1. Leadership commitment and accountability;
2. High quality health care;
3. Seamless coordination of benefits;
4. Integrated information sharing;
5. Efficiency of operations; and
6. Joint contingency/readiness capabilities.

The DoD and VA have already made a number of business process improvements. They have developed a Joint Capital Asset Planning Steering Committee. The departments are also beginning to create joint contracting procedures. They have produced a Web-based medical catalog and will be developing joint purchasing contracts for pharmaceuticals. They also are building shared contracting arrangements for high-cost equipment and maintenance services in areas where the VA and DoD facilities are close to each other.

DoD and VA have also developed a standard reimbursement rate equal to the CHAMPUS maximum allowable charge less 10 percent.

Winkenwerder also stated that the two departments have developed a Joint Incentive Fund. The fund began in October 2003. Each department contributes \$15 million annually. Proposals to use the fund must meet a business case analysis.

The DoD and VA are currently working on a number of initiatives:

- Federal Health Information Exchange – A system that transfers electronic health information on individuals separating from the military. More than 56 million messages have been transmitted so far on 1.78 million unique service members. The DoD information is available to VA providers nationwide.
- Healthcare Standards – A process geared toward developing common standards so that federal agencies can communicate more easily with one another and improve the quality of care.
- Lab Data Sharing and Interoperability – An initiative to facilitate an electronic order entry and retrieval process for VA, DoD, and common reference labs. A pilot system

was tested successfully in Hawaii and more sites will be implementing the system in 2004.

Future initiatives include:

- DoD/VA Interoperable Electronic Health Records – A two-way exchange of records between the DoD and VA. They are looking to have interoperability between VA's Health Data Repository and the DoD's Clinical Data Repository in 2005. A prototype with information on demographics, allergy information, and outpatient pharmacy information will be up in 2004.
- Credentialing – An integrated credentialing system developed by the two departments. Three DoD/VA pilot sites have been chosen.

Winkenwerder concluded that a lot more work must be done in terms of coordinating the two departments, but a structure is now in place to make the changes happen.

During the question-and-answer period, Winkenwerder noted that DoD is currently rolling out a fully integrated health record. Implementation will be complete in 24 months. The records use a different architecture than the VA uses, but the interoperability comes from the standardization of data elements (i.e., codes for diagnoses, procedures, tests). The DoD already uses e-order entry.

Jonathan Perlin, The Veterans Health Administration

Perlin began his time by saying that the DoD and VA share a mission of caring for many of the same people. The departments have made progress in working together, but there are large challenges ahead.

There are currently 26 million veterans in the United States, about three-quarters of whom have served in war time. He stated that about 70 million individuals are eligible in some way for VA services.

The VHA has four missions:

1. To provide health care to the nation's veterans.
2. To provide health professional education. Approximately 60 percent of all health professionals do some part of their training at the VHA.
3. To conduct research. VHA conducts both science-applied and health services research.
4. To provide disaster and emergency back-up medical services.

According to Perlin, 7 million veterans are enrolled with the VHA, and approximately 5 million were seen as patients last year. The number of patients has doubled since 1995. The VHA includes 1,300 sites of care. They have a \$25 billion budget that includes 189,000 employees. An additional 100,000 trainees go through the VA system in any given year.

VA patients are, on average, older, sicker, and poorer than in other health systems. Forty-nine percent are over age 65. VA patients are also sicker than age-matched Americans. They have an additional three non-mental health diagnoses and one additional mental health diagnosis. Forty percent of VA patients have an annual income below \$16,000.

In order to help provide a seamless transition between DoD health care and VA health care, one of the main initiatives is the Federal Health Information Exchange (FHIE). The VA and DoD are working on interoperability between electronic medical records. The two departments are also looking to remove barriers to coordination—by setting standard reimbursement rates, for example. The goal is to create a comprehensive and integrated health care delivery system.

Perlin noted that the FHIE is becoming a model for information technology exchange. He stated that one-in-five lab tests is re-ordered because the data from the first test are not available to the provider. Every VA center has e-medical records. Using remote data view, physicians can retrieve records from any other VA facility. The electronic records also help the VA measure performance.

The VA and DoD are also working on care coordination. They have developed evidence-based care protocols for treating returning veterans. A system has been created to flag the records of returning veterans in order to alert VA staff. The departments have also coordinated with discharge specialists at military medical transitional stations. The VA has assigned social workers to major military treatment facilities to enroll veterans at the time they are discharged from active service.

The VA is also expanding its outreach efforts to veterans. They have created new materials for Reservists and National Guardsmen who are returning from service. Reservists and National Guardsmen are eligible for two years of VA health care, and they are not required to prove that an injury or disease is service-connected. The VA has also enhanced its focus on treating the physical and emotional wounds of battle.

The VA is working with the DoD to develop greater access to military health records by 2005. The VA feels that information is necessary to understand the epidemiology of some diseases in order to inform care about the late-stage effects of exposure/injuries.

CONSOLIDATING HOSPITALS

Alison Cuellar, Columbia University

Alison Cuellar began by noting that her role was to provide an empirical basis for the discussion. She indicated that the number of hospital mergers had declined since 1996. However, this statistic might be deceptive because researchers define mergers as when two hospitals have the same license. In contrast, in some acquisitions where ownership is shared, hospitals retain separate licenses, and these are not reflected in the data. Acquisitions have far outnumbered mergers and they have increased substantially.

Through 2000, the profound changes were based on mergers within local markets (whether or not the local partner was part of a chain). This consolidation was happening in both the for-profit and the non-profit sector. Possible pros included increased efficiency, decreased cost, and more coordination and quality. But the flipside is that there is greater market concentration and bargaining. Unfortunately, most research providing empirical insight on these trade-offs is dated. A handful of newer studies find little or no efficiency gains with evidence of higher prices and mixed evidence on quality improvement. Cuellar's own research in four states shows that, once hospitals join a system, the price increases, volume decreases, and there is no effect on quality. These findings are consistent with concerns about the effects on bargaining power.

Areas of interest for future research include: studies of effects on charity care, whether there are differences in effects in non-profit and for-profit systems, and the effects of concentration on goodwill locally.

Jon R. Cohen, The North Shore-Long Island Jewish Health System

North Shore-LIJ is the third largest non-profit system, with 18 hospitals. They were fortunate and merged after other failed mergers so they could learn from them. Cohen noted that it is important to distinguish three different types of mergers—administrative contracting only, administrative integration where usual corporate functions are merged and layoffs are likely, and a full clinical merger, which has not yet been achieved anywhere fully. As one moves across the spectrum, the problems magnify.

He believes that the standard advice that many consultants give about mergers is a formula for failure: consolidate leadership quickly, reduce or coordinate facilities and administration, and talk about consolidation. When you do this, it is obvious that there will be a winner and loser (e.g., if there are two clinical chiefs).

His advice for success is to move mergers forward without breaking apart the systems. He says that institutions shouldn't merge for the sake of merging but rather to achieve a specific goal, like to reduce residency training, improve quality, enhance research, strengthen leadership, or achieve obvious economics of scale. One hundred percent integration should not be an end goal. Cohen perceives that successful mergers meet the following criteria: they minimize medical school involvement; use flexibility in building leadership models; are patient to develop trust; adopt a senior administrator structure empowered to make decisions with a clear central authority; move forward to develop a third culture that is not one or the other merged partners; and have 100 percent board of trustees commitment to counter end runs.

Lessons he's drawn from experience include:

- Physicians are customers (don't antagonize them).
- Mandate very little, but wait it out.
- Be sensitive to specific issues that are parochial to one campus that could cause a backlash.
- Have comprehensive discussions and vetting of issues.
- Never underestimate the human factor (e.g., the price a particular small program will pay).
- Philanthropy goes to hospitals, not a corporate name.

Cohen believes his hospital's merger has been an advantage to the community that helped address bioterrorism, increase quality of care for patients (e.g., uniform stroke emergency room guidelines), gave physicians advantages like access to telemedicine and to educate across the community, gave residents better experiences, and had an enormous positive impact on both hospitals.

Jeffrey Brennan, The Federal Trade Commission (FTC)

The FTC is charged with enforcing laws on unfair competition in commerce (anti-trust). The main guidance for the FTC comes from Section 7 of the Clayton Act, which includes a standard that is based on the effects of an acquisition to substantially decrease competition or monopolies. There could be some benefits to consumers of mergers in terms of efficiency and only a small percent of mergers are challenged. Historically, mergers were reviewed pre-merger to analyze the available evidence on harm to consumers (higher prices, lower quality) versus benign (neutral) effects or pro-competitive positive effects. But few cases are won if they get to court (FTC and Justice are 7-0).

To assess a merger, the FTC:

1. Defines the relevant product and market for competition (e.g., inpatient versus outpatient). They find facts based on the narrowest bundle of services that would be affected by a merger.
2. Defines the market. This is a big issue since the size of territory affects the analysis.
3. Examines the structure of the market.
4. Examines the likely effect of the merger in terms of purchasers and any offsetting efficiencies (dollars, better quality).

The courts tend to draw larger markets than the government bringing the case. Brennan believes courts reach these conclusions inappropriately from old data on patient flow that do not reflect

how prices change after mergers. The FTC has held hearings on the views of different groups on the increase of bargaining levels after mergers and will issue a report soon.

REDUCING REGIONAL DISPARITIES IN HEALTH SPENDING

Stuart Altman, Brandeis University

Stuart Altman introduced the topic of regional variations in health care utilization and spending by noting that, though scholars have been studying this phenomenon for more than 30 years, it continues to be a difficult problem to solve. In fact, this issue was one of the major concerns that gave rise to the field of health services research. Concerns about the quality and cost of health care lie at the heart of this issue. Understanding the forces that perpetuate this variation and identifying opportunities for reducing unnecessary and inappropriate variation remain important challenges for the field.

Steve Lieberman, Congressional Budget Office

Lieberman offered some new perspectives on the issue of regional spending variation using data on the Medicare population. He noted that current evidence suggests more spending is not necessary better for beneficiaries: Patients in high-spending hospital referral regions received 60 percent more care but experienced no better quality of care or health outcomes than their counterparts in low-spending regions. By lowering spending in all regions to the levels observed in the lowest-spending 10 percent of regions, Medicare could reduce its overall spending by 29 percent.

However, Medicare spending is also highly concentrated in specific patient subgroups. The most expensive 5 percent of patients accounted for 47 percent of total spending in 1995–1999. Moreover, spending for this group of patients was persistently high over time. These spending patterns beg the question of whether it is more productive to target high-cost beneficiaries or high-cost regions in seeking to reduce unnecessary spending variation.

To address this question, Lieberman's analysis showed that when Medicare beneficiaries are ranked by the costs of their individual care, the top 10 percent of beneficiaries account for 65 percent of total spending, whereas when beneficiaries are ranked by the costs of care in their hospital referral region, the top 10 percent of beneficiaries account for only 13 percent of total spending. This suggests that the potential pay-offs from targeting high-cost beneficiaries would outweigh the advantages of targeting high-cost regions.

Lieberman stressed that these two approaches are not necessarily mutually exclusive. Examples of possible interventions to target high-cost regions might include establishing centers of excellence in regions and provider systems that demonstrate the ability to provide efficient and effective care; and introducing new fee-for-service incentive payment systems that reward efficient care and that reduce payments in regions with excessive supply-sensitive care.

By comparison, possible strategies for targeting high-cost beneficiaries include using disease management and case management programs for high-cost patients with chronic conditions, and using predictive modeling and risk-screening applications to identify prospectively patients who are likely to become high cost in the future. It may also be possible to target high-cost patients within high-cost regions, by reducing the number of teaching hospitals in high-cost regions, for example, or by introducing high-cost case management programs specifically in high-cost regions.

Lieberman concluded by suggesting three criteria for evaluating policy interventions to reduce unnecessary spending variation: the efficiency of the targeting; the number of people disrupted; and the return on investment. Strategies that target high-cost regions may be judged as inferior on these first two criteria, because they will target both low- and high-cost beneficiaries in high-cost regions, and because they will affect entire regions of patients rather than just high-cost patients within those regions. However, regional approaches may prove superior on the return-on-investment criterion because they have a greater potential to generate broad changes in the delivery system within high-cost regions that may yield significant cost savings. By comparison, strategies that target high-cost beneficiaries may have little effect on the delivery system.

David Wennberg, Maine Medical Center

David Wennberg argued that unwarranted variation in health care utilization and spending is that portion of the variation that is not explained by illness or patient preferences for care. From this perspective, it is important to distinguish among three general categories of health care when considering variations in use: (1) care that is known to be effective; (2) supply-sensitive care; and (3) preference-sensitive care. The causes of and remedies for variations in care are likely to differ for each category. Wennberg examined these issues using results from his studies based on the Dartmouth Atlas of Health Care and its 308 hospital referral regions for Medicare beneficiaries.

Wennberg found minimal variation between high-spending and low-spending regions in the use of services that have been proven to be effective, such as beta blockers for patients hospitalized for acute myocardial infarction or mammograms for women aged 65–69. Similarly, utilization of preference-sensitive services such as coronary angioplasty or cholecystectomy varied little between high-spending and low-spending regions.

However, utilization of supply sensitive services varied widely between these regions, including physician office visits and specialist consultations, use of diagnostic cardiology procedures and imaging tests, hospital utilization, and care in the last six months of life. In fact, all of the cost difference between high-spending and low-spending regions (a 65 percent difference) was attributable to differences in the utilization of supply-sensitive services.

A particularly controversial finding in Wennberg's analysis was that mortality was found to be higher in the high-cost hospital referral regions than in the low-cost regions. This was true for hip fracture patients, colorectal cancer patients, and myocardial infarction patients. It was also the case for all patient subgroups defined by age, gender, race, and—most notably—level of clinical risk. In fact, the difference in myocardial infarction mortality between high-cost and low-cost regions was largest for the lowest-risk patients who had the least to gain from aggressive treatment.

The study also found that access to care was worse in high-cost regions than in low-cost regions. The overall implication: 30 percent of current Medicare spending is wasted on the overuse of supply-sensitive care that is of no clinical benefit to the patients who receive it. These costs reflect the capacity of the delivery systems in these regions.

Wennberg concluded by summarizing possible interventions to address unwarranted variations in care. To address variations in the use of effective care, both provider and patient incentives are likely to be successful. For preference-sensitive care, the focus should be on shared patient-provider decision-making, including educating and incentivizing physicians to adopt this style of decision-making. For supply-sensitive care, the interventions must address variations in capacity. These approaches may include selective contracting with longitudinally efficient providers, centers of excellence, and comprehensive planning around system capacity.

David Abernathy, HIP Health Plan of New York

Abernathy offered an industry perspective on the issue of geographic variation in spending and service use. HIP Health Plan operates in one of the nation's high-cost regions, as the largest HMO in New York City. The higher costs in this region likely stem at least in part from the large number of academic medical centers: Twelve are located in the city and the market demands that all be included in the health plan's network.

These centers contribute to a high-cost practice style among area physicians. Abernathy argued that HMOs now manage health care and costs only at the margin, and if they managed care more aggressively, their physicians and members would revolt. He noted that, if the plan's provider payment levels become too low or its utilization management too aggressive, the plan becomes uncompetitive in the marketplace.

In the wake of the managed care backlash, most health plans have moved away from aggressive medical management and have responded to the market shift toward open-access PPO-type products. There has been a clear shift away from the staff- and group-model HMO design on which HIP was founded. However, the continued growth in insurance premiums and the recent economic downturn has made the market more interested in cost-containment options.

For this reason, in April 2004 HIP will introduce a "new" product—HIP Classic—that offers a tightly-managed group model HMO product. This is the most cost-effective delivery system that HIP offers, as the costs in its fee-for-service contracted provider network are 20 percent higher than the costs in its traditional group-model network. The health plan is eager to see if the market will respond to this lower-cost, traditional HMO product.

As a Medicare+Choice contractor, HIP Health Plan also must respond to the regional variations in spending and payment that drive dynamics in this program. In Manhattan, Medicare+Choice payments are 106 percent of the fee-for-service payments, so this gives the health plan more options for offering benefits and lowering out-of-pocket costs for beneficiaries than plans in other regions. In general, plans in the high-cost regions have fared much better than plans in the low-cost regions under the current payment system. Policymakers have made various adjustments to the payment system over time to try to address the issue of regional spending variations. However, the overall strategy of relying on Medicare+Choice health plans to reduce regional spending variations in Medicare may be ill-fated, particularly given that these health plans serve only 10–15 percent of the Medicare population.

HEALTH REFORM IN THE 2004 ELECTION

Jeanne Lambrew, George Washington University

Lambrew introduced this session and also served as moderator. The session focused on the health reform platforms of the major Democratic presidential candidates.

Lambrew began with an overview that addressed the question of why health reform was ripe for discussion this year. She noted that health care cost growth in 2002 was 8.1 percent, compared to 6.3 percent in 1993, the last time the nation had a meaningful discussion of health care reform. Health insurance premium increases in 2003 were 13.9 percent, compared to 9.5 percent in 1993.

In addition to private sector costs rising, public expenditures increased as well. Medicaid spending growth is about the same as it was in 1992/93. The uninsured problem is growing again, with the problem expanding to workers in large firms and higher income positions.

The president's health care plan is about \$100 billion over 10 years, which will reduce the number of uninsured by somewhere between 4 and 6 million. The plan includes a \$1,000 tax rebate for individuals purchasing individual health insurance policies, tax deductibility for Health Savings Accounts, and association health plans.

Lambrew noted that all of the Democratic presidential candidates are talking about health care reform proposals. The plans are similar in a lot of respects. Most would cover around 30–31 million of the 43.6 million uninsured. The exception is Kucinich's plan, which would cover all of the uninsured. Dean, Kerry, Clark, and Lieberman aim to cover more people through employers, Medicaid, and new group options. Kucinich's plan uses Medicare as a single-payer option. Most of the candidates' plans also include subsidies to public programs like Medicaid and the State Children's Health Insurance Program (SCHIP), tax credits, and subsidies to employers and insurers in order to make insurance more affordable. In all the plans, there is a lot of focus on information technology, prevention, and prescription drug cost containment.

The estimated costs of all of the Democratic plans are higher than that of President Bush's plan. Dean's plan is estimated to cost \$932 billion over 10 years, Clark's \$772 billion, Edwards' \$590 billion, Kerry's \$895 billion, Lieberman's \$747 billion, and Kucinich's \$6,117 billion.

With the exception of Kucinich's plan, all of the candidates' proposals build on existing public and private insurance systems.

An overview of the 2004 candidates' proposals is provided in "Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals," by Sara Collins, Karen Davis, and Jeanne Lambrew. This Commonwealth Fund publication is available at www.cmwf.org.

Michelle McMurry, Lieberman Campaign

Sen. Lieberman's health care plan is an incremental strategy based on the concept that the nation needs to address its large deficit before turning to the uninsured. There is a focus on technology and reducing costs. In terms of insurance coverage, the plan places its emphasis on children.

Sen. Lieberman's plan creates a MediKids insurance program, which would eventually insure all children regardless of income up to the age of 25. The program, which would be phased in over five years, would be set up as a program similar to the Federal Employees Health Benefits Program (FEHBP), with individuals choosing from different private plans. Private plans would have reinsurance provisions with the government to prevent large losses. Parents would receive subsidies to enroll their children based on the family's income.

Sen. Lieberman's proposal also has a program called MediChoice for adults without access to employer-sponsored health insurance. The program would create a group market for these individuals. Individuals without access to affordable forms of coverage and workers in companies with fewer than 50 employees would be eligible.

The public health component of Sen. Lieberman's plan, according to McMurry, includes an expansion of school-based health centers and more funding for public health activities.

Peter Harbage, Edwards Campaign

Sen. John Edwards promises to look at the whole health care system and fix the existing problems. His health care reform plan includes \$3 billion to introduce 100,000 new nurses into the system. He has a policy on health disparities, which includes a medical translation system in all hospitals. Sen. Edwards supports the Patients' Bill of Rights.

Sen. Edwards believes that insurance coverage should be universal, but the first step toward universal coverage should be with children. Under his system, parents would be required to provide health insurance for their children. Parents up to 500 percent of the federal poverty level (FPL) would receive tax subsidies to purchase health insurance for their children in employer-sponsored coverage, Medicaid, or SCHIP. Public programs would have to simplify enrollment processes. Edwards estimate that such a system would cover 12 million children.

Edwards proposes expanding SCHIP to adults with incomes at or below 250 percent FPL, with adults between 100 and 250 percent paying a contribution toward their coverage. The federal government would pay 100 percent of the costs associated with these newly eligible individuals.

Edwards also favors subsidies for COBRA coverage, encouraging states to set up purchasing pools for small businesses with low-income workforces, and a Medicare buy-in for adults aged 55 to 64.

Other initiatives in Edwards' proposal include placing controls on direct-to-consumer prescription drug advertising, promoting the application of information technology in medical care, the creation of a secure national database for medical records, establishing a \$10 million telemedicine program for rural areas, and an expansion of community health centers.

Mila Kofman, Clark Campaign

Former General Wesley Clark's health care reform plan also targets uninsured children. Kofman noted that one-in-five uninsured individuals is a child. General Clark favors an eligibility expansion of Medicaid to 150 percent FPL for children, young adults to age 23, and adults. The federal government would finance 100 percent of the costs for these newly eligible individuals.

Clark also would provide refundable tax credits monthly for parents with incomes up to 500 percent FPL to buy coverage for their children, through employer-sponsored insurance, Medicaid, SCHIP, or his new group insurance option. Young adults up to age 23 would also be eligible for the tax credits. In addition to the credits, parents would be required to enroll their children in a health insurance plan and young adults would also be required to have insurance.

Clark's plan would also create a new group insurance option based on the FEHBP called the Congressional Health Plan. The plan would be open to all individuals without access to employer-sponsored health insurance.

Another component of Clark's proposal is the creation of an independent expert commission to determine the value of health services and health insurance benefits. The commission would use evidence-based science to provide comparative information to consumers, providers, and purchasers. All federal health programs would be required to offer benefit packages consistent with the commission's recommendations.

Clark is also in favor of giving the Food and Drug Administration enough funding to inspect re-imported drugs in order to allow for drug re-importation.

Sarah Bianchi, Kerry Campaign

Senator John Kerry's plan also includes a mixed public and private model approach, including a new group option. Under Kerry's plan, SCHIP would be expanded to include children in households with incomes up to 300 percent FPL, and parents would be eligible up to 200 percent. The federal government would assume 100 percent of costs for children in Medicaid currently as long as states enrolled 95 percent of eligible children in the expanded SCHIP program. States would receive the SCHIP match rate for children and parents enrolled in the expanded SCHIP program.

Sen. Kerry would also establish a new group insurance option based on the FEHBP. The plan would be open to large and small employers, as well as individuals.

According to Bianchi, Sen. Kerry's plan also encourages employers to provide health insurance by creating a new reinsurance pool, called a premium rebate pool. The pool would reimburse 75 percent of catastrophic costs incurred above \$50,000. In order to participate in the pool, employers must cover all employees and demonstrate how they would pass on cost savings to enrollees.

Dean's Proposal

Jeanne Lambrew summarized the health care proposals of Governor Howard Dean and Representative Dennis Kucinich, as they did not send representatives to the meeting.

Dean's proposal includes an expansion of SCHIP up to 300 percent FPL for children and young adults up to age 25. Adults earning less than 185 percent FPL would also be eligible for SCHIP coverage. The federal government would finance 100 percent of costs for these newly eligible populations.

Dean also proposes a new group health insurance option based on FEHBP, called the Universal Health Benefits Plan. Any insurer who offered coverage through FEHBP would be required to also participate in the Universal Health Benefits Plan. A reinsurance pool would protect health plans from adverse selection in the Universal program. Individuals who buy coverage through the new program would receive tax credits for premiums that exceed 7.5 percent of income. In addition, employees who lose their jobs and purchase COBRA would receive a 70 percent premium subsidy.

Dean's proposal also includes an automatic enrollment system that would use the income tax system to assess individuals' health insurance coverage annually and then enroll them in the appropriate insurance program if they are not already enrolled. Individuals would have to affirmatively opt out of a program.

Other components of Dean's proposal include the encouragement of information technology in medical care, development of standardized electronic medical records and medical prescriptions, increased controls on direct-to-consumer advertising, and the establishment of a new Health Care Institute within the National Institutes of Health that focuses on effectiveness studies and translating research into practice.

Kucinich's Plan

Representative Dennis Kucinich's plan is the only single-payer proposal among the candidates' plans. His approach is essentially to expand Medicare to all. The plan would be phased in over 10 years, beginning with children and older adults. He proposes to fund the program through a 7.7 percent payroll tax that would replace the current employer deduction for health insurance. Kucinich argues that his plan boasts universal coverage and administrative simplicity.

CONGRESSIONAL HEALTH POLICY AGENDA

A Webcast of the session and transcript are available at www.kaisernetwork.org.

Linda Fishman, Senate Finance (majority)

Fishman provided background information on how the Medicare bill evolved. There had been a leak from somewhere that the Administration was considering a bill that would link the addition of a pharmaceutical benefit to enrollment in a preferred provider organization (PPO) or managed care plan. In the Senate, this led to consternation as Sen. Grassley and others had said they wanted an equal benefit regardless of plan choice. Sens. Grassley and Baucus then consulted with Sen. Frist about legislation that was marked up with bipartisan support. Sen. Frist set a two-week period for debate and the bill passed June 26 by a vote of 76-21 in the Senate.

The conference committee staff work was led by John McManus and worked initially in a bipartisan way on the issues that were easier to resolve—regulatory reform, the prescription drug card, etc. Sen. Grassley's great concern was that rural provider payment wasn't being addressed sooner in the negotiations and he had his staff stop going. However, by early September work began again with many late hours and much negotiation. Sen. Grassley was concerned that the bill be one that the Senate would pass; that meant that he needed support from Sen. Breaux. A compromise bill was adopted on December 8, 2003. It is not a perfect bill but, as someone said, it is "as good as it can be" given that it was a product of many compromises. The prescription drug benefit will cover only a quarter of what seniors spend now on drugs.

Fishman then reviewed where she saw the legislative agenda going in the Senate over the next year. From where she sits, she saw the prospects for a technical corrections bill in 2004 to be quite small. The main thing happening in 2004 is the prescription drug card, and that was developed closely with the administration so issues have probably been worked out. In terms of the larger bill, if any technical corrections are needed, 2005 would be soon enough.

Over the next year, they see the future as focusing on non-Medicare issues. Sen. Frist has appointed a task force to address issues dealing with the uninsured on which Sen. Grassley serves. The Finance Committee will have to work on the Trade Adjustment Act (TAA) and other tax issues that need attention. They plan to have hearings on Medicaid oversight. While there will not be a lot on Medicaid reform overall given the short term, there will continue to be a focus on fraud and abuse.

There also will be oversight hearings on the Centers for Medicare and Medicaid Service's (CMS) implementation of the new Medicare Modernization Act. The committee will be very watchful of that. There is concern that the quality work started by Scully and in the bill doesn't fall through the cracks. Also, there is concern that, while the bill gave CMS \$1 billion to implement the new law, that amount could be insufficient to do both what the new law demands and what CMS usually does.

The work of their committee will be affected by scheduling. There are a lot of trade issues pending that were delayed by the focus on Medicare last year and there are always tax issues. Re-importation of drugs will come up with a focus on trade policy with other countries, not just as the way it has come up this year as a payment issue.

Liz Fowler, Senate Finance (minority)

Fowler began by recalling that Sen. Baucus had talked last year at the conference and she reminded the audience that what followed was a lot of what he had outlined. She noted that the Medicare bill had gotten a lot of criticism from the Democratic perspective and that Sen. Baucus, given his role in the bill, was very attuned to hearing that and agreed with many of the comments. The bill was a compromise. If Sen. Baucus wrote the bill, the 2010 demonstration, HSA provisions, and stabilization funds would not be in it and probably neither would the assets test.

Fowler said that Sen. Baucus, if he were speaking, would say that he supported the bill because there was \$400 billion on the table and he didn't want to lose the opportunity to get something done versus fighting. The compromise includes an equal benefit regardless of plan choice and has very generous low-income subsidies. Even the assets test is indexed. Even if flawed, the bill was better than no bill, he'd argue, though the process was flawed and that will be hard to overcome. The Democrats were not in charge and they did not set the rules. The good news is that there is a long lead time for the bill and thus opportunity for adjustment.

What they are hearing most about is:

1. Pharmaceutical pricing and the non-interference language. The fact that the Congressional Budget Office said that it won't affect costs is important to note.
2. The true out-of-pocket costs and the disincentives for employers, Medigap, and others to fill the gap.
3. The burden on states. These should be seen early on.
4. The importance of education and outreach to help people understand the bill.
5. On the low-income side, the fact that some duals will now pay more and there are concerns about the formulary and appeals process.

She noted that people could expect Democratic amendments to address these issues.

Fowler also observed that one of the best things about the bill's passage is that there is now an opportunity to discuss other issues. Health care coverage and the uninsured are back on the agenda. Sen. Baucus has worked before on expanding the State Children's Health Insurance Program (SCHIP) and the TAA. He is concerned that few are using the latter and that premiums are very high.

In terms of the longer-term reform, there will be a lot of time to talk about these issues and revisit options. She noted that Families USA said that tax credits are a 10-foot rope for a 40-foot hole. The question is what they will be able to do about the uninsured this year. She concluded by saying she expected a busy and exciting year.

Dean Rosen, Office of the Senate Majority Leader

From Dean Rosen's perspective, regardless of people's political or policy view, in 10 years they will look back on the Medicare Modernization Act (MMA) as the most significant bill, though he doesn't mean to minimize the challenges that still remain in implementing policies, etc.

Rosen noted that, in 2004, health care has become one of the most significant issues (first or second on many lists); the interest level has not been this high since 10 years ago when the Clinton plan was under debate. Second, this is a different Republican party and a different approach to health care. He noted that 2003 showed a very active president who is not afraid to be aggressive and a Senate that is bold. Going beyond prescription drugs was a major change from the past.

In terms of 2003, the Medicare bill is the most significant accomplishment. Usually there are many smaller bills that are incremental rather than the singular focus on the MMA. Any bill that size will be flawed, he said. We'll have the facts when it is implemented and we see the results, but he thinks this is the most significant health care expansion in generations that targets assistance to those who most need it: anyone with catastrophic costs.

There are many other provisions in the bill. Much of the debate wasn't about delivering the pharmacy benefit, but risk-bearing private insurers, with premiums and benefits not uniform across the country and more like the Federal Employees Health Benefits Plan than current Medicare. There are standards for electronic prescribing and incentives to do it. There is a start to linking payment to quality and providing a signal that business practices are changing to more of a purchaser than payer for large entitlements. Also significant are the HSAs, means-testing Medicare premiums, and the \$50 million for effectiveness research through the Agency for Healthcare Research and Quality (AHRQ). There is a lot to focus on in the bill with some significant reform.

In looking toward health policy in 2004, there will be areas of bipartisan progress even though some differences exist. The Democrats want to change the Medicare bill but Rosen said he doesn't think this will happen in 2004. The debate will build on HSAs and the uninsured and we may see some progress. A lot of the discussion will also lay the groundwork, including the task force on the uninsured that Sen. Gregg of New Hampshire is heading. The audience should expect a return to the medical liability bill with a narrower target. Areas of interest where there is bipartisan agreement include issues related to genetic discrimination in the workplace, patient safety, and electronic medical records.

Bridgett Taylor, House Energy and Commerce (Minority)

With the chairmanship of the House Energy and Commerce Committee up in the air because of the uncertainty around Rep. Tauzin's potential moves, there is some ambiguity on the agenda. Bridgett Taylor thinks there will be some changes made in the MMA, and that it is important to keep thinking about it. From her perspective, everyone thinks that the donut hole should be eliminated, but it is a matter of money. If the economy improves there will be talk of eliminating it and also re-importation, which is important, though issues of safety also are a concern. Though there is uneasiness over premium support, the low-income provisions of the MMA do a lot of good. Issues of growth in cost sharing for drugs and Medicaid support for the cost share are

important. Benefits are important but, she noted, access and appeals will be harder under Medicare than they were under Medicaid.

Aside from pharmaceuticals, she observed that while all the talk has been on how great managed care was, we have moved from 95 percent of fee-for-service costs to 109 percent and, with the risk adjuster, it will go higher. She wondered what market forces are in play. She also noted the lower overhead for Medicare than in private plans.

In terms of insurance reform, she expressed concern that we not go backward by taking Medicaid and SCHIP, which now work well, and block-granting them. There is concern about pushing to build onto these programs versus developing new ones. Some also worry that tax credits could mean fixed dollars that buy a lot more for some folks (e.g., healthy, young, single people) than others. Taylor noted that the TAA used a percentage of premium subsidy, not fixed dollar, but that even 65 percent of premium was not enough to gain much participation in the program.

Without a chair, Taylor said she wasn't able to fully speculate on the agenda. They will continue to work on medical errors with the Senate. A House bill has already passed on medical errors and she hopes to work out any issues with the Senate. Taylor also said that the House Energy and Commerce Committee will hold hearings on prescription drug prices and the average wholesale price (AWP) and on Medicaid fraud.

Joel White, for John McManus, House Ways and Means (Majority)

White began by saying that many of the issues in the Medicare Modernization Act (MMA) had bipartisan support. While there has been a lot of negative press now, this will change in June when prescription drugs cards are available and seniors see they get immediate savings. These will be significant—the \$600 credit applies to Medicare beneficiaries below 150 percent of the federal poverty level and since costs for a typical senior are \$1,282, the funds are a significant help.

In terms of 2006, he sees high private sector interest in PPOs and Medicare Advantage. The regions are not yet determined and plans are nervous about this. Since CMS can establish 10-50 regions, it means that some regions could be multi-state in nature (e.g. pairing up Montana up with some other states), whereas you could also have multiple regions within California. There will be premium variation across the regions. Seniors can maintain drug coverage if they have it now through their employers or Medigap H, I, or J—enrollment in the program is totally voluntary. The bill also did a lot of other things. He said the MMA is the best rural and suburban package for providers ever passed with \$25 billion to focus resources on rural areas versus urban areas which have received the lion's share of the money in the past.

In the future, the uninsured will dominate the agenda. Health Savings Accounts (HSAs) may be expanded, they are going to look at association health plans, costs for malpractice insurance, the Trade Assistance Act (TAA) tax credit, patient safety, and implementation of a health information infrastructure. He suggested that the 43 million uninsured referred to is a misrepresentation as only 21.1 million lack coverage throughout the year.

CRITICAL ISSUES FOR THE STATES

A Webcast of the session and transcription is available at www.kaisernetwork.org.

Arkansas Governor Mike Huckabee

Gov. Huckabee reflected on the policy issues now facing his state and stressed the futility of trying to isolate health policy from the many other policy issues facing states. Health is inextricably linked to education, economic development, crime, and public safety, and many other issues. Policymakers therefore must consider how investments in health (or lack thereof) will play out in these other policy arenas.

For Arkansas and many other states, education, Medicaid, and prisons make up 91 percent of the state budget. The state legislature is now considering a 20 percent cut in non-education spending in order to comply with an education court order. However, the state's efforts in education cannot succeed without sound health policy to ensure that children can come to school healthy and ready to learn.

Huckabee acknowledged that states face a variety of challenges related specifically to health and health care policy. The rapidly growing cost of Medicaid programs, for example, presents serious difficulties for states. In Arkansas, persons dually eligible for Medicaid and Medicare represent 20 percent of the Medicaid population but 35 percent of the cost. Huckabee argued that the federal government should pick up a larger share of these costs as part of its responsibility for Medicare beneficiaries.

Lifestyle and behavioral issues are a major driver of health care costs in Arkansas and nationally. Sixty-five percent of the state population is overweight or obese, and 25 percent of high schoolers are overweight or at risk of becoming so. Obesity and related behavioral and lifestyle issues result in increasing rates of costly and avoidable medical conditions such as diabetes, hypertension, and heart disease. Nationally, obesity costs \$92.6 billion annually and it is generally preventable.

Arkansas now has 235,000 people with diabetes, and the prevalence is 77 percent higher among African Americans. Diabetes is at least the 6th leading cause of death (probably higher due to underreporting), and mortality is three times higher among African Americans. Arkansas spent \$55 million in hospital costs alone for diabetes last year. Huckabee argued that these costs are simply unsustainable for states, and the health disparities are unacceptable.

To address these challenges, Huckabee called for leadership at the policy level, leadership on a personal level, and leadership with the pocketbook. On a personal level, Huckabee noted that it is hard to push policies that call for lifestyle and behavioral change without showing a personal commitment to lead such change. Since becoming governor, he has changed his personal diet and exercise habits and has lost 80 pounds.

On the policy level, Huckabee led the charge to start the ARKids program, which provides insurance coverage to children who lack access to coverage from other sources—primarily children of working parents who do not earn enough to pay for health insurance. That program now serves 265,000 children statewide.

Arkansas also led a successful statewide ballot initiative to ensure that all of the state's tobacco settlement funds would be used for public health rather than for other purposes. These funds amount to \$1.6 billion over 25 years or approximately \$62 million per year. The legislature wanted full discretion over the spending of these resources but citizens, by a 64 percent margin, voted to devote all of the money to public health. Arkansas is targeting 32 percent of these dollars specifically to minority communities and minority health issues, in a state where minorities represent 15–16 percent of the population.

Another example of policy leadership is Arkansas' new Gold Standard Initiative. This initiative, to be officially unveiled in five weeks, will introduce changes in the benefit structure of the state employee health plan to create incentives for state employees and their families to improve their health behaviors and lifestyles. Employees will pay lower cost-sharing for their insurance coverage if they take advantage of preventive screenings and check-ups, reduce tobacco use, increase physical activity, and improve nutrition and dietary practices. It is important to recognize that these kinds of approaches will not have immediate pay-offs in terms of cost savings, but over the long term they will have positive effects on health.

Huckabee noted that the third area of pocketbook leadership is particularly difficult but critically important in the current environment of state budget deficits and rising costs. Demand for care is increasing, while state revenues are static or declining. Nevertheless, states must begin to invest more in upstream prevention and public health activities if they are to address the health care crisis. States cannot afford to continue spending money on the sick while ignoring the conditions and processes that make healthy people sick.

The politically difficult challenge is to devote a larger share of health care spending to prevention and incentives for becoming and staying healthy—as the Gold Standard Initiative is designed to do. Policymakers must lead by investing real dollars in prevention, acknowledging that this is important for society's future even if there is no immediate pay-off politically or economically.

NON-VISIT-BASED COMMUNICATION BETWEEN PATIENTS AND HEALTH PROFESSIONALS

Steven Katz, The University of Michigan Health System

Katz's presentation focused on the emergence of online communication between patients and providers.

According to Katz, patients want to communicate online with their providers because they are frustrated with between-visit access. In addition, more and more people are connected online and view e-mail and the Internet as everyday means of communication. Providers are also frustrated with their communication with patients. They view current methods of communication, such as phones, as burdensome. Providers feel there is a mismatch between the mode of communication and what they are trying to do with the communication.

Katz stated that the Internet is a good communication method because it is asynchronous, has a far reach, can be tracked, and is secure.

Sixty-six percent of Americans had any Internet use in 2000, and that number has risen to 71 percent in 2003. Still, not everyone is online. There are "digital divide" issues in terms of age, education, income, and race.

Katz reported on the results of a survey of 120 primary care doctors at the University of Michigan Health System. According to that survey, the doctors made an average of 12–14 e-mail contacts with patients per 100 visits, and 76–80 phone contacts per 100 in-person visits.

There are some challenges in increasing the use of Web technology. First, many patients lack experience on the Internet. Physicians are concerned about how using the Web will affect their workload and what the value of using the technology really is. Organizations worry about the return on investment, building and integrating Web tools, and the fact that there is no road map for how to build a truly integrated system.

Katz outlined several components of a Web portal. There are service-related features, such as the ability to make an appointment, get medication renewals, and check on lab results. There is also the clinical communication tool that allows patient-to-physician communication. And finally, there is the patient health record, which is populated both from the provider and the patient.

Katz highlighted three steps to the roll-out process: building the business model for using Web-based communication; building/buying the tools and creating a roll-out strategy that includes education and promotion activities; and developing rules of engagement, and allocating physician time.

For those physician organizations that have implemented Web-based tools, the patient uptake is usually slow at first. So far, resource offsets are uncertain. Clinicians and staff have demonstrated high acceptance. There also is somewhat of a "cultural divide" between patients and clinicians about what messages are being communicated. Patients don't want their messages being triaged by staff as much as clinicians would like to see.

The prognosis for Web-based communication is good, according to Katz. Patient ability and access is increasing, and will increase further with the expansion of broadband technology. In addition, there are better online communication tools and clinical data systems available. Katz stated that we are at the beginning of the “J Curve.”

Paul Yang, The Palo Alto Medical Foundation (PAMF)

Yang started by reporting the results of a Harris Interactive Poll exploring the reasons that patients want to use the Internet for patient-clinician communication. Seventy-seven percent want to be able to ask a question when a visit isn’t necessary; 71 percent want to be able to make an appointment request; 71 percent want to get a prescription renewal; and 70 percent want to view lab test results.

Yang then provided an overview of Palo Alto Medical Foundation’s (PAMF) online services. Patients at PAMF can make appointments, access their electronic medical report, view lab results, and view notes about a recent office visit, including links to appropriate Web sites. For instance, if a doctor recommends a specific diet or exercise, the patient will get a link to a Web site that explains the diet/exercise. The notes also include links to definitions of terms and information on results in patient-friendly language.

Patients can also e-mail doctors with questions. When the doctor responds to the question, the individual will get a message in their in-box that there is a message waiting for them at PAMF Online. The individual then signs back into PAMF Online and views the secure message.

PAMF’s early experience with their system is that 11–12 percent of their patients—around 17,000—are using the online services. Yang noted that more than 1,500 patients over the age of 70 are using the service. He said that the patients who are enrolled are sicker and on more medications than the average patient, indicating that this is not a service solely for the worried well.

Patients at PAMF can get the basic services of PAMF Online for free. These include the appointment requests, lab results, and electronic medical records. In order to use the physician messaging system, patients pay an enrollment fee of \$60 per year. The fee, according to Yang, was “picked out of the air” in order to not be too much of a burden, but also to indicate that they are getting physician time from the service.

Patients enrolled in the system like the physician messaging feature the most, followed by the access to test results. Physicians also like the system; 90 percent report being satisfied.

Yang noted that Web-based systems must be integrated with electronic medical records and must be secure in order to be successful.

Development of a Web-based communication system also poses some leadership challenges. The business leadership must have the vision, capital, and infrastructure to develop the system. There are a number of standards, laws, policies, and identifiers that must be thought through. Finally, a system for reimbursement needs to be considered, including the conditions for reimbursement and documentation.

Yang concluded that a Web-based system of communication is just a tool to create a better relationship with the patient.

Robert Berenson, The Urban Institute

Berenson discussed the payment issues surrounding non-visit-based communication. He noted that some of the issues surrounding payment for e-communication also pertain to phone communication.

Berenson noted the relative merits of phone versus e-mail communication. He said that some data is more efficiently communicated over e-mail, but that phone communication is better for two-way conversations. One problem with phones is that they require two people to participate in the interaction at the same time..

Under current payment policies, some payers assume that pre- and post-visit time spent on a patient is included in the payment for the visit. In addition, in many settings, the marginal incentive is to get another visit in the day, not to have time for non-visit communication (i.e., physicians who are paid based on how many patients they see in a day).

Berenson noted three theoretical concerns about payments for non-visit-based communication. First, there would be high transaction costs and a high frequency of claims for very low payment services. There is also the potential for abuse. And finally, some are worried about moral hazard in that non-visit-based communication would become an add-on to care rather than a substitute for a visit.

With non-visit-based communication, there may be a role for patient payment, rather than third-party payment. The patient's time saved may make the out-of-pocket cost for a non-visit-based communication worthwhile. Having the patient pay may also mitigate some of the moral hazard issues. However, there are issues regarding what is the unit of payment (per message, per problem, or a flat rate per year) and equity for those with less money or less access to technology.

Berenson noted that some insurers are beginning to reimburse for e-consultations as an alternative to an office visit. He stated that the AMA-CPT has recently decided it will define a code for e-consultation.

Also, some of the administrative services that can be done electronically, such as setting up an appointment, shouldn't require additional payments.

Potential uses for e-mail in health care communication include administrative services, clinical consultation, and physician-to-physician communication.

There are a number of different potential payment options for non-visit-based communication:

- A voluntary subscription to a service.
- A fee-for-service payment for a defined service.

- Increase the value of an office visit.
- Capitation payment for all non-visit-based communication with a patient.
- Condition-specific disease management fee. (This would be a modified form of capitation for targeted to a certain population.)
- Pay for performance if communication results in better outcomes.

OBESITY: STRATEGIES TO COMBAT THE EPIDEMIC

Jessie Gruman, The Center for the Advancement of Health

Gruman opened the session by examining the growing national attention being paid to overweight and obesity. The 2001 Surgeon General's report attracted public attention to the epidemic, and in the years following this report the public saw an upswing in reporting on the problem from major print and broadcast journalism outlets. The enormous and growing burden of disease associated with obesity has made for a compelling story: 300,000 excess deaths per year attributable to obesity and \$79 to \$100 billion per year in annual costs. The prevalence of obesity has grown from 15 percent of the population in 1978–80 to 31 percent in 1998–2000. Two-thirds of the population is now overweight or obese, and 15 percent of teenagers are overweight. Growing public concern about the obesity epidemic has led to a number of actions by both government and the private sector to address the problem.

Alan Rulis, The Food and Drug Administration

Alan Rulis described how the FDA has begun to address the obesity epidemic through its regulatory and oversight responsibilities for food and drug products. The FDA's Center for Food Safety and Applied Nutrition has been active on this issue through the Obesity Working Group, which brings together an array of experts from across the agency.

Rulis stressed that obesity is a multifaceted and multi-sourced problem that will require an array of solutions working together. Part of the problem is related to personal lifestyle and behavioral choices, and this will require efforts to educate the public and encourage individuals to take more responsibility for maintaining and improving their own health. Other contributing factors are the food industry, which develops and markets processed foods, as well as restaurants and the prepared food industry. Health professionals have critically important roles to play in educating, screening, and counseling patients on obesity. Consumer groups and the public sector also have unique roles to play in addressing the issue.

A variety of federal government agencies are approaching the obesity issue from different angles, including agencies within the U.S. Department of Health and Human Services such as the Centers for Disease Control and Prevention (CDC), National Cancer Institute, the Office of Public Health and Science (OPHS), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), as well as agencies outside HHS such as the U.S. Department of Agriculture, the U.S. Department of Education, and the Federal Trade Commission. There are multiple statutory and legal frameworks that these agencies can bring to bear on the problem.

The FDA's frameworks relate primarily to food labeling and consumer education under the authority granted by the Public Health Service Act, the Food, Drug and Cosmetics Act, the Nutrition Labeling and Education Amendment (NLEA), and the Federal Trade Act. These laws give the agency authority for developing mandatory regulations as well as voluntary industry standards and guidelines.

The FDA's Obesity Work Group recently conducted an inventory of the various efforts underway in the federal government to address obesity, which yielded a 30-page list of activities.

These activities included the *STEPS for a Healthier US* initiative sponsored by both the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Agriculture (USDA), the HHS Health Summit scheduled for April 2004, a variety of research efforts underway at the National Institutes of Health, and a variety of programs in which the CDC works directly with states.

Moving forward, the Obesity Work Group within FDA will address a number of related efforts, including:

- Developing a coherent message for the public regarding obesity and dietary choices;
- Developing educational activities to support the public message;
- Developing food labeling policies to better inform consumer decision-making;
- Developing policies and guidelines for restaurants;
- Addressing the need for obesity therapeutics, including drug approval issues;
- Conducting research into the behavioral, biochemical, and psychosocial aspects of obesity; and
- Maintaining active stakeholder involvement in the FDA's obesity activities.

The FDA will produce a report in February 2004 on these issues. The major themes will include: the need to pursue both short-term and long-term solutions; the preference for incentives rather than regulation in addressing major contributors to obesity; the importance of caloric balance (total caloric consumption and energy expenditure) rather than fat/carbohydrate consumption as the key issue to obesity; the importance of lifestyle choices and behavioral motivations; the imperative for science-based regulation of food and drugs; and the need for clearer labels to inform consumer choices.

Rulis noted the importance of considering how to measure the success of our collective actions against obesity. The measure should not be the level of governmental activity on this issue. Rather, we need to see a change in population outcomes and a shifting of the obesity curve to the left. This kind of change will require a long, sustained effort, but in the short run we can at least stop the movement in the wrong direction.

Stephanie Pronk, Watson Wyatt Worldwide

Pronk described the range of worksite programs and policies that employers are beginning to consider in response to the obesity epidemic. Growing numbers of employers are recognizing that obesity affects not only health care costs, but also productivity, absenteeism, workforce turnover, disability program use, workers' compensation costs, and family medical leave. Workplace policies to address obesity, therefore, have the potential to affect many different outcomes that employers and employees care about.

Pronk noted that there is a growing body of evidence showing that body mass index (BMI) affects work performance, the ability to get along with coworkers, and absenteeism. As a result, employer coalitions such as the National Business Group on Health have begun to pay more

attention to workplace interventions. However, relatively few employers so far have implemented new policies and programs related to obesity. Employers can take a wide range of actions to address obesity, ranging from the easy “no brainer” policies to more difficult and costly options. These include:

- Stocking vending machines with healthier offerings and subsidizing these offerings to encourage consumption.
- Mandated obesity prevention education sessions offered as part of mandatory OSHA training. These sessions can be integrated into an employer’s existing training structure to make participation automatic.
- Fitness-for-duty requirements that establish maximum BMI levels for certain job functions that could be unsafe for obese employees to perform.
- Coverage for obesity prevention and treatment services as part of the employer’s health plan benefit structure. This may involve treating obesity as a disease. Possible examples include the use of “step therapy” for obesity, requiring patients to try nutritional and physical activity interventions first before more aggressive and expensive treatments are applied (e.g., drug therapy or bariatric surgery).
- Mandatory physical activity breaks for employees, such as two 10-minute breaks per day. A drawback is that there is no way to ensure that employees use these breaks for physical activity.
- Health insurance premium differentials for individuals who engage in obesity prevention activities.
- Employee compensation arrangements linked to participation in obesity prevention activities, such as bonuses, gain-sharing, and other variable compensation strategies.

Pronk acknowledged that some of these strategies may raise concerns about employee discrimination under the Americans with Disabilities Act (ADA), but noted that currently obesity is not a covered class under ADA.

Michael Mudd, Kraft Foods

Mudd examined the food industry’s role in addressing the obesity epidemic. He stressed the importance of recognizing that obesity has multiple causes and remedies, and cautioned against blaming or demonizing any one stakeholder. Mudd argued that there is a tendency to over- or under-emphasize some contributing factors in examining the obesity issue, and this ultimately detracts from efforts to establish comprehensive, multifaceted responses to obesity.

The nutrition and food industry have undertaken a variety of voluntary actions to address the problem of obesity in recent years. These actions include developing new product guidelines and standards regarding portion size and nutrition labeling, improving the nutritional composition of existing products, improving consumer information and marketing efforts to better educate consumers about the nutritional composition of foods, and public policy efforts to urge more governmental support for research and consumer education around nutrition and physical activity. In the marketing area, Kraft has taken a hard-line stance against the marketing of food

products in schools, and has developed new nutritional guidelines for in-school sales of food products. Kraft has also voluntarily adopted new energy and nutrition labeling policies that display information per 100 grams of product, thereby helping consumers make better comparisons between food products.

In the advocacy arena, the food industry is urging policy action on a number of fronts, including: improved nutritional labeling; expanded research on consumer decision-making and information needs; physical activity requirements in schools; stronger enforcement of USDA regulatory limits on in-school food sales; incentives for schools to offer low-calorie foods and to increase nutrition education; changes in zoning and building codes to promote physical activity in communities; incentives for employers to offer worksite physical activity and nutrition interventions; and support for public awareness campaigns around strategies to prevent obesity. Other factors that need further study and intervention include television programming, video games, and nutrition training within medical school curricula and continuing education opportunities.

THE COURTS AS HEALTH POLICYMAKERS OF LAST RESORT

M. Gregg Bloche opened the session by noting that the courts were inventing health policy. In the last four years, the Supreme Court has addressed managed care in four major cases. There has been a lot of effort to make sense of the recent health care rulings.

James Blumstein, Vanderbilt University Law School

Blumstein said he'd start from the perspective that one of the central issues facing courts is how to introduce economics into medical care decisions, how to introduce accountability (a legal issue), and what considerations are appropriate for courts (e.g., a single standard of care or not). He stressed that language is important. Some talk of systems versus non-systems and others use a paradigm of markets and industry. Doctors talk of rationing and say no. Economists always ration and look at this as just one type of resource allocation. The underlying difference affects the premise about whether you provide all beneficial care versus only care that is worth its cost, and how to provide it (e.g., should you do the sixth stool test).

The traditional model of medical care assumed consumer ignorance and asymmetry of information drawing on work by Ken Arrow. Those with a market approach say the solution is to disclose and not substitute for the market. A recent North Carolina case illustrates this by reference of a child hospitalized for 30 days who had a mental condition. Coverage ran out and the hospital discharged the child, who later committed suicide. The question is whether the hospital could discharge even if the physician did not recommend discharge, but did not broach the question of moving to a public facility because the hospital did not wish to reveal that coverage mattered.

The issue is whether the hospital is obligated to provide care even after coverage runs out. Saying yes assumes cross-subsidies. But the court ruled elsewhere that inducements to ration are important in reining in medical care and you can't disregard economics. Blumstein is concerned that the cross-subsidies be made explicit politically rather than left to the courts (e.g., state legislation).

The Wickline case suggests that payers can be liable for the design of a health plan (e.g., financial incentives). Medical necessity as a fundamental issue comes out of the professional paradigm and suggests there is no tradeoff with costs. Market-based approaches work when there is informed consent and they allow the patient to be in the game. If people are afraid of a managed care bait-and-switch, you need an adult conversation to deal explicitly with what the plan pays for and any discrepancies between that and what the patient wants. The Health Savings Account could be an important source of individual responsibility.

Judge John L. Coffey, U.S. Court of Appeals for the Seventh Circuit

Judge Coffey was responsible for the Igraham decision, which has been controversial and overturned, but he believes it was right. The case was about a young woman in a health care program who had abdominal pain. Though the doctor had some suspicion of appendicitis, the woman was told to go home and in two weeks go to a far-off hospital for a follow-up examination. After seven days she was in excruciating pain and went to a nearby hospital with a ruptured appendix. She eventually recovered, but instead of the usual five-to-seven day recovery

period, it took 14 days and the patient experienced anxiety. The doctor was an employee of the hospital and the incentive plan shared cost savings with the doctors. The patient sued for malpractice and was awarded \$35,000. When the patient wanted more, she sued under the Employee Retirement Income Security Act (ERISA) in a case that eventually went to the Supreme Court. The Supreme Court ruled there was not a fiduciary relationship and ruled against the patient.

Coffey's view is that we can agree that the courts are not a place to deal with medical problems—the legislature is. The courts must deal with individual cases and the facts before them. Often, judges have to proceed when there is a lack of certainty in the health regulation and the scope of legal remedies, leaving the courts “flying blind.” The court has to decide what is experimental and what punitive damages should be; this often leads to foolish decisions and high malpractice costs.

There are many players that influence the high cost of health care, and they all should have to face up to this. Consumers need information to ask intelligent questions. State legislators can hold hearings but courts have to deal with only the facts in a particular case. The court has come to be viewed by the public as a “jack of all trades” for all questions and any problems that the legislature doesn't solve.

M. Gregg Bloche, Georgetown University Law Center

There remains a basic tension between the paradigm of medicine and markets, and that is reflected in the decisions. Judge Souter embraced incentives and the use of cost/benefit analysis and marketplace issues. Then, two years later in *Rush Prudential*, he said that state statute is not preempted by ERISA and supported medical necessity tests. Which paradigm should be embraced?

Health law and politics shape health care systems. The standard wisdom is that policy involves command and control, incentives, and levels of enforcement. It stands to reason that in legal fights you have winners and losers. But in the health field the legal outcome also is affected by perceptions before cases are decided. You can win a suit on medical necessity but it takes a long time and in the meantime stocks can drop and there can be a backlash. This is what happened to managed care in the 1990s where they ultimately won the legal battles but lost the war. Legal conflicts are a venue for bad stories that aren't necessarily individual experiences (i.e., public relations problem). You can't go back from this.

PRE-ELECTION PUBLIC OPINION ON HEALTH ISSUES

Robert Blendon, Harvard University

Blendon explored what recent public opinion polls suggest about the likely fate of health policy issues in the upcoming presidential election. The most important statistic to know in this regard is that 15 percent of the population is uninsured but only 8 percent of likely voters are uninsured. As a consequence, the uninsured are dependent on “the kindness of strangers” to create pressure for health policies that expand coverage. Blendon noted that there are no polls that ask uninsured people what they think of the candidates and their policy proposals. Rather, the insured voter is the key actor in this process.

Recent polls indicate that dissatisfaction with the current health system is growing, as is concern about the uninsured. Voters are concerned about rising costs and are increasingly worried about their future ability to maintain insurance coverage. The growing numbers of media stories on the uninsured have helped to raise awareness and fuel concerns about this issue. As of December 2003, voters were nearly as dissatisfied with health care as they were with the economy.

Voters show broad support for policies to expand coverage for the uninsured, but this support drops when the policy details are discussed. The public has a very low knowledge of how health policies and programs work. Moreover, they are generally satisfied with their current health care and coverage (though worried about the future), so they feel they have something to lose if the proposal is too far-reaching. For this reason, hybrid proposals typically do best in the polls—proposals that leave current coverage options in place and expand on these options to address people who fall through the cracks. These proposals are also much harder for opponents to torpedo. However, it is important to note that voters are very much opposed to anything that involves rationing.

The public is divided on their willingness to pay more taxes to cover the uninsured. This suggests that financing issues will be the most difficult to address in the pre-election debates and in the post-election policies. There will be considerable pressure to phase in coverage expansions over years in order to minimize their financial impact.

Blendon argued that candidates will need to achieve broad coalitions of support for their coverage expansion policies if they are to succeed. If there are too many alternative plans being proposed and backed by many different interests, no plan is likely to succeed. Candidates need to make compromises in their policies in order to avoid or pre-empt criticism. The key to winning this policy game is to win the support of the insured voter.

Bill McInturff, Public Opinion Strategies

McInturff noted that the health policy environment has changed significantly since the early 1990s’ failure of comprehensive health care reform, suggesting that the stage may be set for another try at major reform. Policymakers and the public have preferred to address health care issues on an incremental basis since the early 1990s, including tinkering with HMO reform, consumer protection, Medicare costs, and prescription drugs. Now, however, voters are showing the lowest levels of satisfaction with their own health care since January 1992. Voters are concerned about their growing out-of-pocket expenditures on health care.

Masking some of the public concern about health care is the fact that Democrats and Republicans generally agree on the issues, so there is not yet much of a polarizing force in the policy debate. However, there are some differences across parties in health policy options and these could begin to divide voters moving forward. Democrats, for example, favor a roll back of the Bush tax cuts to finance reform. The issue of health care coverage versus tax cuts is a big area of difference between the parties.

In light of these developments, McInturff predicts that Republicans will face pressure to put a more comprehensive health care reform plan on the table this year during the run-up to the elections. Specifically, he predicts a proposal to expand coverage for the 8.5 million children who remain uninsured. McInturff maintains that, if Bush loses the election, it will be over the issue of health insurance coverage. Consequently, he expects Bush to propose a more expansive coverage policy that will secure his re-election and thereby usher in major health reform during Bush's second term.