

**Session Summaries of the
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These session summaries have not been reviewed by the presenters from the meeting or professionally edited.

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2005 NATIONAL HEALTH POLICY CONFERENCE

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THE ADMINISTRATION'S HEALTH POLICY AGENDA

Mark McClellan, Administrator, Centers for Medicare and Medicaid Services

Dr. McClellan focused on anticipated health care issues on which CMS (and more broadly, HHS) will be focusing in 2005.

He began by noting the upcoming year is critical for the Medicare program, as CMS continues implementing various facets of the Medicare Modernization Act (MMA) and gets closer to the implementation of the Part D benefit in January 2006. 2005 will also be a big year for Medicaid as well. Medicaid's rising costs are not sustainable but there are more "good ideas" than ever before for solving the Medicaid issue.

Dr. McClellan stated that he wants to emphasize physicians and patients in his remarks. Medical science is moving more toward individualized care. Medical care needs to be more personalized and prevention-focused, and that is one of his main goals for Medicare and Medicaid. MMA will help fill in the gaps in preventive care under Medicare.

The final regulations were released one week ago on Part D. CMS is laying out a lot of details in those regulations. MMA offers "real help and security" for everyone in Medicare, and the average beneficiary will save 53 percent on drug costs when Part D is implemented in 2006. That includes help for people with supplemental retiree coverage, Medigap, etc. Every senior can now get help. Those with low incomes will get even more help; one-third of beneficiaries will qualify for assistance that will cover almost all of their prescription costs. They will have choices; all prescription drug plans will cover brand and generic drugs, and will cover the drugs that beneficiaries need.

The regulations also guarantee that those in nursing homes can enroll in drug plans and plans will have to contract with pharmacies that serve nursing homes. Dual-eligible beneficiaries will be auto-enrolled in a drug plan on January 1, 2006.

The coverage under Part D will be less costly than the Medigap premium for plans that include prescription drugs and will provide much more coverage. A retiree drug subsidy of \$1,000 is available, too, if: 1) the employer provides a comprehensive drug benefit that is at least as good as Part D, and 2) the employer pays for the benefit. So there is no employer windfall. Many employers can actually do better with other approaches, by wrapping around Part A and B. This approach is worth \$900 of support from the government. Many large employers—maybe 25 percent—provide access only and don't pay any portion of the premium; for these employers, there will be no employer subsidy.

Actuaries expect this to be a large benefit for Medicare beneficiaries. States will also be better off; it should save states \$8 billion over 5 years. State prescription assistance programs will be able to provide the same or better coverage at less cost.

Beneficiaries who join Medicare Advantage will get a Medicare drug benefit as well. (And Medicare Advantage plans must offer at least the level of benefits in fee-for-service (FFS) Medicare.) Regional PPOs will be an additional option as of January 1, 2006. These are important new options for those without access to supplemental coverage through Medigap or

retiree coverage. Studies have shown that Medicare Advantage enrollees pay \$700 less in costs per year, relative to FFS enrollees. And sicker enrollees in Medicare Advantage may save \$2,000 per year.

Medicare will have 100 percent risk adjustment by 2007, so there will be much more of a focus on chronic and disabled populations. It is modeled after the Federal Employees Health Benefits Program (FEHBP). CMS is bringing in Abby Block who managed FEHBP to help manage this process.

In January 2005, CMS added new preventive benefits for beneficiaries with heart disease and diabetes, as well as a new “welcome to Medicare” physical for all new beneficiaries. This closes a big gap between what Medicare covered historically and good preventive medicine. For the first time, Medicare coverage reflects the recommendations of the U.S. Preventive Services Task Force. To close the preventive care gap in Medicare, CMS will also need to educate beneficiaries so that they are aware of the new preventive benefits. Government and non-government organizations will have to help seniors in the community.

Medicare historically has paid for specific services. CMS has made a lot of progress through the prospective payment system, but the agency can't pay out anything if physicians help prevent costly hospitalizations. But CMS pays out a lot for hospitalizations.

Medicare has the Chronic Care Improvement Program for beneficiaries with chronic conditions. There are 300,000 beneficiaries enrolled in 10 regions of the country. CMS is doing this through pay for performance. CMS is also bringing pay for performance to hospital performance and also has a demonstration program for physician group practices. This could help make the health care system work better at a lower cost, so there is a business case for this.

CMS is working to include modern information technology, too. E-prescribing standards were released one week ago.

CMS is working on ideas for reforming and improving Medicaid as well. We need to aim for quality care at a lower cost. Addressing drug overpayments is important. CMS will also go after those who are sheltering money in order to access Medicaid for long-term care. HHS Secretary Leavitt said yesterday that we could save \$60 billion in the Medicaid budget. There are some programs like the North Carolina Community Care Program, in which 2,000 physicians follow a disease management program and give better care at lower cost to many beneficiaries as a result. There is a similar program in Washington state. Medicaid should provide financial support for these types of programs. States shouldn't have to go through a lot of hoops to do these sorts of efforts. We could also save money through more home- and community-based services to get people out of institutions, providing beneficiaries with more choice and control, often at a lower cost. Medicaid still emphasizes institutional settings; there is an institutional bias. We need to structure the system so it follows the disabled person's needs rather than the person following the services into a nursing home.

McClellan also noted Medicaid needs to reduce the burden on states to do other approaches such as purchasing pools, allowing states to add tax credits, and health savings accounts. CMS and the administration also want to expand access to community health centers for the uninsured.

McClellan stated that all proposed initiatives for Medicare and Medicaid share the goal of better access to care, better quality, and more efficient and effective care.

During the question-and-answer period, McClellan answered a question about whether CMS favored programs such as the Utah Medicaid waiver, which expands the breadth of individuals covered but shaves benefits. McClellan responded that under statute, Medicaid is a very comprehensive benefits package, which is critical for many in Medicaid—such as the disabled and very low income; however, for many potential beneficiaries, Medicaid coverage is not available today because of the rigid benefit requirements. For those with somewhat higher incomes who are not disabled, he said the agency could allow less comprehensive benefits—“a Chevy, not a Cadillac.”

McClellan was also asked about the potential for pay for performance to be a cost saver for Medicare and he responded that he is confident in pay for performance initiatives that are done well. Many employers and plans have already adopted approaches that reward better quality and help lower costs. He noted that we need to work together to identify valid measures and mentioned the Physician Group Practice Demo, which includes the University of Michigan, Geisinger and Dartmouth—in which incentives are set up such that physician groups only get financial rewards if they lower spending.

Trish Leddy from Rhode Island’s Medicaid program briefly discussed the financial problems facing the SCHIP program in her state (including the state’s need to draw from Medicaid funds) and asked whether sufficient funds would be appropriated when SCHIP comes up for reauthorization. McClellan responded that CMS wants to provide support for innovative states like Rhode Island that allow them more flexibility.

Finally, McClellan was asked about the disparity of evidence needed for preventive versus other services covered under Medicare. McClellan stated the preventive care needs to be a larger part of Medicare spending, and we need to build into Medicare the capacity to study and build evidence for prevention.

David Brailer, National Coordinator for Health Information Technology

Brailer stated that the inflection point for information technology (IT) was when the Institute of Medicine (IOM) linked quality with IT, and noted that the President talked last year about the role of IT in the health care system, so this is becoming a prominent issue. Brailer noted that the reasons underlying the focus on IT is not technology itself, but rather other reasons like error reductions in hospitals and reducing costs associated with duplication of services. The retail industry has invested heavily in IT and retail is gaining 1.5 percent annual growth in productivity; health care is not doing that.

Brailer stated that IT should be used to level the playing field and help consumers, to help develop a more consumer-driven health care economy in which consumers compare providers and make informed choices. This approach will ultimately lead to greater value.

Brailer’s office released a strategic framework in July 2004 to let others know where they were going. He highlighted several important pieces of the framework:

- We need to ensure every clinician (not just physicians) uses an electronic health record (EHR) when they see patients.
- IT tools need to be inter-operable, meaning that information flows with patient when they move from setting to setting and place to place. “Paper records are not safe and are not private.” Inter-operability could bring major savings to health systems. (Brailer gave example of Indianapolis’ linking of EHRs across systems.)
- We need to expand capacity for the electronic health record, allowing the ability to pull data together in a secure way. (Brailer noted that a recent Kaiser Family Foundation study found that 30 percent of Americans carry paper records with them to the doctor, which is a very large proportion when you consider that only 50 percent get care regularly.)

Brailer also addressed the question of “why now?” He noted that there were two significant reasons. First is the adoption gap, which refers to large hospitals and physician practices being much more likely (e.g., 15 to 17 percent of large hospitals) to adopt IT than their smaller counterparts (about a 5 percent adoption rate). Second is the interoperability gap. The health care system is creating “electronic moats” but data should instead be an available, portable asset.

During the Q&A, Brailer was asked several questions about reconciling compatibility issues, creating uniform standards, etc. Brailer said that if we continue without standards for interoperability, everyone will proceed with their own IT system and that could actually make the problem worse. Brailer noted that if physicians and systems try to solve their own problems now with EHRs, it will be very difficult to try to link them later. When asked if pharmacists (in addition to other clinicians) should have access to EHRs, Brailer responded that this was not a question Washington could answer, but rather is one for communities and others to decide, noting that there are clearly a lot of privacy issues related to EHRs.

INFORMATION TECHNOLOGY INNOVATIONS HERE AND ABROAD

Don Detmer, President and CEO, American Medical Informatics Association, and professor at the University of Virginia

Don Detmer served as the moderator for the session and noted that since 2003, interest in health information technology (HIT) has increased. He said that health systems are investing more money in information technology and states are beginning to show real interest. While states are beginning to show interest, he noted that information technology must be addressed as a multi-state issue.

Detmer stated that HIT needs to achieve and demonstrate greater value in four areas: clinical, public health, personal health records, and research uses (for instance, clinical trials).

According to Detmer, President Bush has given HIT more prominence by talking about it in his 2004 State of the Union address and also by putting more funding in the area. The Office of the National Coordinator for Health Information Technology (ONCHIT) also recently released its strategic framework.

In 2004, major activities included the formation of the Certification Commission on Healthcare Information Technology (CCHIT) and the President's Commission on Systemic Interoperability. The President's Commission is now active and has a report due by October 2005.

Detmer stated that the Scandinavian countries have the most developed HIT systems. In Europe, England and Wales have undertaken a major system initiative, and Germany has a number of HIT initiatives underway. Europe is now trying to shape some policies at the European Union level, including an initiative to allow for the transfer of patient information.

The United States is generally ahead of Europe in terms of the development of personal health records, but there are some good examples in some of the new European states. Whereas in the United States hospitals are further along in terms of HIT, in Europe the general practitioners are generally further along.

Canada has developed a HIT system where the federal government sets some standards, but the provinces are in charge of developing their own initiatives. Detmer stated that Australia probably has the most robust, well-thought-out plan.

In terms of HIT standards, two global leaders have emerged: SNOMED (the systemized nomenclature of medicine) and HL7 (Health Level 7). These are both sets of standards for classification and nomenclature that are used within HIT.

Detmer then noted a number of federal HIT initiatives/projects:

- Detmer said that a physician organization would be hard-pressed to participate in CMS's pay-for-performance demonstration without HIT capacity.
- Medicare Quality Improvement Organizations (QIOs) are going to provide training in IT skills
- AHRQ recently awarded \$100 million over 5 years for work to promote the use of HIT through the development of networks for sharing clinical data or for planning, implementing or demonstrating the value of HIT
- AHRQ also named a National Technical Resource Center
- The National Cancer Institute released its cancer Biomedical Informatics Grid (caBIG), a network connecting cancer research organizations.
- Four biotechnology centers were named.

Detmer stated that activity in HIT was more frantic in 2003, but in 2004 there has been more coherence. He said that the issues of quality and IT are starting to come together.

Detmer said there is good and bad news on the HIT front in 2005: The bad news is that HHS Secretary Thompson is gone and he was a good advocate for HIT. Also, Iraq continues to be a

major issue and that takes away focus and possibly funds from HIT. The good news is that new HHS Secretary Leavitt is knowledgeable about HIT and should also provide good leadership.

In terms of legislation, HIT issues are likely to come up in revisions to the Stark amendments and possibly in any amendments to the Medicare Modernization Act. He said that HIT probably won't get a big cash infusion, but would see fewer dollars spread out over a number of initiatives.

In terms of federal agency activity in HIT in 2005, AHRQ is developing a privacy and legal framework for electronic health records. Detmer stated that policy statements are forthcoming on this. Also, CDC has identified quality and IT as key skills in their agency.

Louise Liang, MD, Senior Vice President of Quality and Clinical Systems Support at Kaiser Permanente

Kaiser Permanente is the nation's largest nonprofit health plan with 8.2 million members. It serves 8 regions that include 9 states and DC. Kaiser is currently completing the roll-out of its program-wide information system. The outpatient system is in place in all of the organization's 8 regions, and they are now finishing the roll-out of the inpatient system. All physicians affiliated with Kaiser also have access to the system.

Kaiser Permanente's outpatient IT system is called HealthConnect. The system integrates a patient's clinical record with appointment setting, registration, and billing.

The clinical content of HealthConnect includes information on evidence-based medicine, workflow models, convergent medical technology, charting tools, decision-support reminders and alerts, drug alerts, and patient self-care guidance. Population care management experts, including the Kaiser Permanente Care Management Institute, review the clinical content. Clinicians and regional representatives are involved in all states of development and testing. Frontline users also validate the usefulness and usability of the system.

Dr. Liang gave an example of the HealthConnect's usefulness for a physician seeing a patient with diabetes. When the doctor brings up the patient's record, the physician sees all of the person's vitals, alerts for all tests or vaccinations that are indicated, and links to web pages of information on selected topics relevant to a patient with the given diagnosis and history. Dr. Liang stated that HealthConnect's decision-support tools can lead to improved care delivery and patient safety, as well as better research on outcomes of care. She noted that the system also optimizes efficiency by providing templates for documentation and orders that support clinician workflow.

Kaiser Permanente patients also have access to the system. Patients can access their own medical records, make/change appointments, send email messages to their doctor, check lab results, access health information, review their eligibility and benefits, or look at an account summary. One worry physicians had was that patients would abuse the email system by sending too many messages. Kaiser reports that most members have been using the secure messaging system appropriately to send short, to-the-point messages that are within the context of an established relationship. Dr. Liang stated that the volume of email a physician receives is related to how much the clinician encourages patients to email.

Affiliated providers also have access to the online system. They can also view medical records, request appointments, send messages to other doctors, check lab results, and make referrals.

Dr. Liang summarized the benefits of web access to patients as being the ability to participate in their own care at their own convenience, visibility of their own medical history, and 24/7 access to high-quality health information. For physicians and clinicians, the web access provides access to online referrals, 24/7 decision-support tools, access to critical patient information, and expanded opportunities for collaboration and patient sharing.

Dr. Jonathan Perlin, Acting Under Secretary for Health, Department of Veterans Affairs

According to Dr. Perlin, the Veterans Affairs' (VA) investment in information technology has allowed the agency to serve more veterans under the same budget.

VA patients are on average older, sicker, and poorer than patients in other health systems. They have an additional 3 non-mental health diagnoses and one additional mental health diagnosis. Forty percent of VA patients have an annual income below \$16,000.

The VA has gone to a virtually paperless system. Every VA center has electronic medical records. Dr. Perlin noted that in other care settings, one-in-five lab tests is re-ordered because the treating physician doesn't have access to the results when they need them. In contrast, VA physicians can fetch records from any other VA facility. The electronic records also help the VA measure performance.

Similar to Kaiser Permanente's system, the electronic health records that VA clinicians have access to contain built-in reminders for lab tests and other orders. Clinicians can just click on a tab and order the test.

Dr. Perlin noted that the VA's investment in information technology has also helped the agency improve the quality of care. For instance, one study that looked at pneumococcal vaccination rates found that while nationally only 50 percent of the elderly or others with chronic illness appropriately receive pneumococcal vaccinations, two-thirds of VA patients with chronic lung disease were vaccinated. Among those patients, there was a 43 percent reduction in the number of hospitalizations for pneumonia and a 29 percent reduction in death compared to those who were unvaccinated.

Dr. Perlin also showed that the Veterans Health Administration (VHA) has achieved about an 80 percent influenza vaccination rate among its population, compared to 65 percent for the state of Iowa and higher than the Healthy People 2010 goal. VHA has also achieved similar results for other benchmarks such as cervical cancer screening, breast cancer screening, and diabetes care.

VHA is also now offering veterans its Health eVet program, which provides veterans electronic access to their health records as a means of empowering them to improve their own health.

The VHA is coordinating their electronic systems with the Department of Defense and is also in talks with Kaiser Permanente. The VHA also offers its electronic records software free of charge, although organizations would likely need to hire someone to train them on how to use it.

Glen Steele, Jr., MD, PhD, President and CEO, Geisinger Health Systems

Geisinger Health Systems serves 41 counties in central and northeastern Pennsylvania—a very stable population of about 2.3 million. Many families have lived there for multiple generations. There are about 650 physicians in Geisinger Clinic group practice and 41 community practice sites. Geisinger also has an insurance company, Geisinger Health Plan, which has about 243,000 subscribers in the 41 counties.

Dr. Steele discussed Geisinger’s information technology innovations. He stated that Geisinger serves a relatively small and rural population. He wasn’t sure if the results they have seen are generalizable to other sites.

Geisinger initiated its electronic health record roll-out in outpatient settings in 1995. They are now completing the roll-out of its inpatient system. There are currently about 3 million patient charts in the inpatient system. The electronic health record system was designed to improve quality and safety, efficiency, and customer and clinician satisfaction.

Geisinger’s electronic health record (EHR) allows for order entry, note documentation, labs, radiology, operative alerts, clinical decision support, and physician DRG entry at the time of visit. Patients have access to records through MyGeisinger web site.

Geisinger has moved away from a proprietary model for its electronic health records system. GeisingerConnect allows external physicians to link into the system and obtain episode information, hospitalization records, and referrals. Dr. Steele noted that 162 physician practices have full EHR access. They are now working with AHRQ to apply health information technology to small, community hospitals as a way to disseminate their caregiving.

Dr. Steele stated that the EHR increases quality and safety by making it “easier to do the right thing at the right time.” The system checks drug-to-drug interactions and drug allergies. The records include patient-specific, real-time alerts and reminders. Documentation is standardized, complete, searchable and legible. The system also allows for aggregated reports on aggregated data.

Geisinger is now integrating pay-for-performance into its service lines. Geisinger hopes that engaging in pay-for-performance will allow them to expand their market and improve and streamline care. They are currently undertaking three pay-for-performance projects, two of which are based on the EHR.

The first project provides financial bonuses to primary care physicians if they are rated in the “best category” on selected quality measures. Geisinger has found that for such projects to succeed, information needs to be transparent and accessible. In order to make the system work, Geisinger needs to be able to monitor the effects on individual physician productivity. With EHRs, they can tell what the productivity response is in real time.

The second project is CMS's pay-for-performance demonstration. Under the CMS project, providers are rewarded for coordinating and managing the overall health of Medicare beneficiaries with chronic disease. Dr. Steele stated that Geisinger doesn't predict receiving a lot of extra money from participating in the demonstration, but they are doing it anyway. He stated that the EHR is essential for the project to track and improve quality, and improve safety. The EHR allows for performance reporting by department and physician.

The third project is a pilot project for episodic care with Geisinger Health Plan (GHP). Under the project, three high-volume diagnosis-related groups (DRGs) have been identified (CABG with catheter, CABG without catheter, and total hip replacement). For those services, the patient will be informed of best practices and they will participate in monitoring the care they receive through a checklist. In addition, the patient will receive their own materials that let them understand their contribution to a good outcome. Performance parameters that Geisinger will be rated on include mortality, length of stay in the intensive care unit, complication, infection rate, patient functional status, patient satisfaction, and cost per episode. Under this demonstration, if the results are less than expected, GHP doesn't get charged. If they results are as expected, Geisinger gets the DRG payment. If results are more than expected, Geisinger gets the DRG payment plus a bonus payment.

Dr. Steele stated that the EHRs need to show benefits to four constituencies: patients, providers (both physician and hospital), the payer, and the insurance company. The principle is that payment is only made for acceptable outcomes and there is no expectation of a bonus payment for simply doing the right thing. Dr. Steele noted that he is not sure if Geisinger's experience is generalizable or scaleable to other populations, but they feel an obligation to experiment.

Question and Answer

One audience member asked how the panelists have gotten people to trust electronic health records. Dr. Steele responded that organizations must make people understand the value-added over paper records. For instance, for an elderly member, the value may be that their children who live far away can access the records and help manage care. Dr. Liang stated that some of the discomfort is actually among doctors. However, she stated that the trust issue has never really been an operational issue when they rolled out the system. .

Another audience member asked about what these organizations were doing in terms of interoperability and making their systems work with outside systems. Dr. Steele said that Geisinger is not currently linking their work with any other systems right now because there really is no one else in their region that has the balance sheet to do information technology. The VA is rehosting its architecture so it has standards that work with other systems. One panel member noted that the real issue is building standards, and then building the momentum around those standards so that a business model can be developed. Dr. Steele noted that some vendors are probably creating a worse problem by trying to serve a very niche market and creating products that won't work with other systems.

TEN YEARS OF TRACKING HEALTH SYSTEM CHANGE: THE EVOLUTION OF COMPETITION

Len Nichols from the Center for Studying Health System Change chaired the session. Nichols stated that in the early 1980s, two articles provided articulate visions of the health care market. One (by Bruce Vladeck) focused on government intervention, while the other (by Jack Meyer) focused on a market-based approach. Nichols stated the market-based approach won and we are relying more on market incentives, but “disappointment still reigns” with health care.

Paul Ginsburg, The Center for Studying Health System Change

The Center for Studying Health System Change recently celebrated its 10th anniversary. Looking over the Center’s research over the last decade, Dr. Ginsburg gave an overview of the health care system from 1995 through the present.

Circa 1995:

Employers were completing the shift to managed care in 1995; managed care enrollment had increased from 27 percent in 1988 to 73 percent in 1996, and HMOs were the most popular type of plan in 1996. For plans, it was a period of aggressive expansion into new markets, and the Medicare market was seen as the most lucrative. There was also a notion that only the top 3 to 4 plans would be viable in each market. It was the classic underwriting cycle. There were more restrictive managed care products at this time (e.g., narrow provider networks, gatekeeping).

There was substantial consolidation in the hospital industry during this period, and a notion that the independent hospital was not viable. Hospitals were in a weak bargaining position and worried about the risk of exclusion from plan networks. Hospitals were experiencing excess capacity.

This era also saw the formation of primary care and multispecialty group practices, as well as independent practice associations and physician practice management companies. Physician groups had weak leverage with managed care plans and were increasingly subject to capitation. There were low physician price (as well as hospital price) increases over this period.

Late 1990s and early 2000s:

By the late 1990s, there was a severe managed care backlash. Consumer fears of excessive restrictions surfaced and consumers wanted a choice of provider. Employers were able to respond vigorously because profits were high and the labor market was tight. Plans developed less restrictive products (broader physician networks, PPO products, etc.). Patient Bill of Rights proposals were popular at this time.

Financial incentives were weakened (or non-existent) for both providers and consumers. There was a reversal of the movement toward integrated delivery systems. As part of the backlash, specialists regained dominance. And hospitals gained leverage over plans. In many cases, the local Blue Cross Blue Shield plan was too strong for managed care plans to compete

with. Costs increased during this period and there was an extreme increase in pharmaceutical spending. Premium increases were in excess of cost trends.

Recent trends:

Recently, there is more patient cost sharing, particularly in the area of prescription drugs. There is a vision of consumer-driven health care. Concerns about consolidation have emerged (as the Federal Trade Commission attempts to control hospital mergers).

Ginsburg said he thought several potential market developments might be on the horizon. First, there will be a maturation of patient financial incentives. Second, there may be a return of utilization controls (e.g., on imaging procedures). Third, Medicare is focused on increasing the accuracy of its prospective payment system and private insurers are eager to follow Medicare in this regard. Fourth, Ginsburg expects that information technology will become significant and begin to reshape markets. (He noted that such a development could have significant implications for small practices.) Fifth, continued hospital consolidation will be driven by the need for capital; also, there is a potential shift to more for-profit ownership of hospitals.

Ginsburg concluded by saying that some of the observed changes in health systems are cyclical, such as the role of patient financial incentives, utilization controls, and insurer versus provider leverage. Other changes are secular, such as increasing consolidation in the hospital market. There is a vision of the health care system competing on value but current structures are an obstacle to that.

Mark Pauly, University of Pennsylvania

According to Pauly, in 1995 everyone thought that managed care would rule. People also believed that the integrated delivery system was the best provider. There was a sense that “the back of health care cost inflation had been broken.” Experts were happy with quality (or at least quiet about it) but consumers were unsatisfied with care.

In contrast, Pauly said, managed care is “defanged and declawed” by 2005. There is no longer much difference between plans, and the integrated delivery system idea had lost billions. Health care spending growth has returned. Experts are terribly worried about quality. Consumers are satisfied (or at least quiet) with care but complain about costs.

According to Pauly, managed care didn’t slow the rate of spending growth because it is not attacking the sources of growth. Inefficient or low quality care is not a source of spending *growth*; inefficiency would have to be getting worse every year for it to be responsible for the growth in spending. What is driving cost growth is costly new technology. Pauly stated that competition worked the way it’s supposed to—there are now new products and more choice, but these are costly.

Pauly noted that since the 1950s, the proportion of the U.S. population with insurance (the “extensive margin”) has grown and the percentage of costs paid out of pocket (the “intensive margin”) has fallen. Insurance coverage has gotten more generous over time. The real question is whether the extra spending on health care is worth it to people? Pauly wondered where the

competitive market is on technology. Where is the plan that's selling last year's technology at last year's premium?

Karen Davis, The Commonwealth Fund

Davis stated that enrollment in managed care increased rapidly in the 1990s, and the insurance industry has become concentrated. The real growth recently is with the preferred provider organization (PPO). One other big shift is toward for-profit plans away from not-for-profit plans.

According to Davis, the three largest plans in most states have over 50 percent of the state's enrollment in managed care. Plans have also increased their profitability over the last 15 years. Davis noted that, comparing the U.S. to other industrialized countries, the average annual growth rate of real health care per capita spending of the U.S. has been average. The U.S. has high levels of health care spending, however, and high out-of-pocket spending, with one-fourth of Americans spending more than \$1,000 out-of-pocket annually on health care (a level that is much higher than other countries).

Davis pointed out that administrative costs are the fastest growing component of health care costs in the U.S. In fact, this is one of the downsides of managed care. Medicare has grown more slowly in terms of administrative costs than other types of insurance, and Medicare really hasn't relied largely on managed care. Administrative costs are 13.6% in the private market and 2.9% in Medicare.

While there are long waiting lists for elective surgery in other countries, Davis noted that patients in the U.S. have a problem getting appointments to see their physicians. Only one-third of Americans have been with the same physician for 5 years or more, and Davis stated that this was another downside of managed care.

Davis concluded with the following points. First, we should focus more on the supply side and improve transparency, accountability, and the reporting of performance measures. Second, there have been a lot of downsides to managed care, and it has had only average performance with regard to cost. Medicare's experience with managed care has not been a success story and Medicare managed care costs the program more than fee-for-service now.

Question and Answer

The first question focused on managed care's ability to measure quality. Davis stated that the U.S. is higher than other countries on preventive care and that is likely related to HEDIS measures required of managed care plans.

At another point, Paul Ginsburg agreed with Karen Davis that more focus on the supply side is needed. Ginsburg also noted that demand has to have a role but that role needs to be refined.

When asked about what level of education is needed for consumers to make good choices, Mark Pauly responded that some may want to be their "own epidemiologist" under consumer-

directed health plans, or there could be a proxy shopper for patients, such as a nurse, that helps individuals decide.

The panel was also asked about whether pay for performance will grow in the future. Karen Davis stated that she thinks it's going to grow, but there's always a question of whether there will be a backlash. She continued that pay for performance should be done well with a single set of measures. Paul Ginsburg stated that many good ideas falter because less sophisticated employers think about the short term only, such as only focusing on this year's premiums.

When asked about what role federal tax policy has played, Mark Pauly responded that competition has worked less well than it should. Health savings accounts are a notion that is gaining prominence. The government should be neutral regardless of what plan you choose, and one should not be able to tax shield money for out-of-pocket costs. In the individual market, there should be tax breaks for a wide variety of plans.

When asked about whether managed care is headed for a severe downcycle, Paul Ginsburg stated that underwriting cycles are going to be muted in the future. Entry barriers are higher now because managed care is the dominant product. Mark Pauly added that trends in costs have been the same for self-insured plans and there's no underwriting cycle for them.

TACKLING MALPRACTICE REFORM AS A HEALTH POLICY PROBLEM

Michelle Mello, Harvard University

Michelle Mello noted that we are beginning the fourth year of the most recent malpractice crisis. This time, what started as an insurance issue evolved into a provider issue, then (in late 2002) into public health issue. It ultimately morphed into a voter and political issue, as politicians asserted that malpractice claims drive health care costs.

Mello observed that the malpractice system is costly—though, she said, not in the way many people may think. Moreover, in her view, available tort tools are not helpful in navigating a way out of the problem. Comprised of claims, claims administration, and defensive medicine, medical malpractice costs equal an estimated 0.5 to 1.5 percent of health care costs—with claims and claims administration together representing just 0.3 percent of health care costs. The highest research estimate of the cost of defensive medicine, \$20 billion, accounts for about 1.1 percent of health care costs.

But, Mello said, malpractice premiums are high, and the system is wasteful: administration and litigation costs account for 55 percent of malpractice premiums. “Frivolous” suits account for a minority of claims costs: about half of claims involve medical error and, among those that do not involve medical error, about half result in an award to the patient. In addition, the current system creates an environment of fear and reluctance by providers to report and address medical errors, with no apparent deterrent effect on the practice of poor quality health care.

Summarizing the results of a survey of physician practices in Pennsylvania regarding their response to rising malpractice premiums, Mello said that a high proportion reported that they would defer or forgo capital improvements, attempt to increase their patient caseloads (to reduce

average cost), and restrict their scope of practice. Relatively few would consider moving their practice to another state or retiring early.

While there is a strong argument for policy intervention, Mello argued, the conventional tool kit for tort reform offers little reason for hope. Research studies suggest that a \$250,000 cap on noneconomic damages would have a modest impact on malpractice premium costs—perhaps reducing premium increases by as much as 13 percent. Similarly, the use of screening panels and expert precertification to bring suit are likely to have little impact. Because screening panels find it difficult to decide whether there is evidence of malpractice without hearing all of the evidence, they are disinclined to screen out claims. Moreover, none of these methods addresses under-compensation of patients.

Because malpractice claims are not a major cost driver, and flat caps on noneconomic damages are insensitive to the level of injury, Mello argued that malpractice reform needs to look in new directions. She suggested developing schedules of damages to compensate patients fairly, but not to expect big impacts on premiums in any event. To develop a system that will improve care, she proposed development of a system that would improve medical record keeping and access, encourage free discussion among providers, and incorporate incentives and systems to improve quality of care.

Robert Berenson, The Urban Institute

Dr. Berenson noted that, while most of the public thinks that frivolous lawsuits are a major cost driver, other and much greater concerns about health care are not addressed. In a major clash of stakeholders—with the Bush administration and defense bar on one side, and the plaintiff bar and consumer advocates on the other—the public interest is not discussed. Trial attorneys are reluctant to acknowledge that change is needed, and providers are reluctant to acknowledge the current system's rewards to poor quality.

Berenson noted that the Bush administration's proposal is based loosely on California's reforms enacted in 1975, including a flat cap on noneconomic damages. But in addition, it would put limits on punitive damages (which are not common); establish a schedule of attorney fees (in lieu of contingency fees) and periodic payment of awards; establish a statute of limitation and allow use of evidence of collateral sources in calculation of economic damages; and limits on damages for products and drugs. The House passed these provisions on a party line vote; it did not pass the Senate (requiring 60 votes to avoid filibuster), where the vote also largely followed party lines.

In the current Senate, Berenson said, it is "still not clear where the President gets his 60 votes." Protections for pharmaceutical companies against punitive damages, "in a post-Vioxx world," may impede the legislation. Also, since it was last introduced (in 2003), the blood incompatibility incident at Duke University hospital has received national media attention, potentially changing the political dynamic about protections for institutions as well.

Finally, many states have acted in the last year, potentially changing the imperative to take what is traditionally a state issue to the federal level. If the issue does move forward at the national level, the level of cap could be in play, Berenson said. The California cap, were it

indexed to 2005, would be at least \$500,000. Other areas for compromise would likely include the proposed exemption for drug and equipment manufacturers.

William Sage, Columbia University School of Law

Sage began by proposing three rules for meaningful medical malpractice reform: 1) “think big;” 2) “start small;” and 3) limit the discussion to health care, not making it a general political issue. Doctors and lawyers, he noted, have a longstanding professional conflict. He noted that politics threatens to make medical malpractice reform a “poster child” for general tort reform.

The mismatch between negligence and litigation, he said, is two sided: some lawsuits are unjustified, but there also are uncompensated injuries and high rates of avoidable error. Among the problems that afflict the system are poor processes, restricted information, limited nonmonetary remedies, extreme delay, and lack of quality feedback to providers. Moreover, the focus on individuals rather than “systems” is misdirected, he said: it fosters a fear of harm to reputation that impedes providers from reporting medical errors and developing systems to improve quality.

Among the options that should be considered, Sage said, are administrative compensation (no fault); enterprise liability; early offer of settlement; and accelerated payment of damages. The debate, he said, should focus on the system’s larger problems of high error rates and inadequate compensation. Therefore, targets for reform should include the legal process, improvements in patient safety, and restructuring of the liability insurance system in ways that are more appropriate to medical care.

“Thinking big” about malpractice reform, he said, includes development of a system that is proactive (not reliant on litigation) and “keyed” to avoidable injury (not negligence). Such a system might rely on lists of compensable events (ACEs) with sliding-scale compensatory damages, immediate disclosure of medical error, early mediation, and feedback to patient safety processes. It would have a health system focus, system accountability, diversified liability risk, coordinated injury management, malpractice insurance purchasing efficiencies, and safety improvement.

Vehicles for reform could include state-based demonstration projects, potential employer initiatives, and—significantly—the Medicare program. Medicare’s unique position as the nation’s single largest health care purchaser would make it a compelling party to reform, Sage said, though it has been conspicuously absent from the debate.

Ongoing state-based demonstrations (see www.nap.edu/books/0309087074/html/) include development of new public infrastructures (e.g., definitions of avoidable injuries; a prospective schedule of noneconomic damages; and development of data on access, cost, and safety), changes to the legal environment (e.g., modification of tort liability; narrowing exceptions; waiving subrogation; and development of organization-based coverage), and changes to the patient safety environment (e.g., error reporting and analysis; patient involvement, and peer review protection).

In addition, the Institute of Medicine (IOM) has developed specific options for reform that include:

- Provider-based early payments, a system in which provider organizations would elect to pay economic losses and predefined noneconomic damages for identifiable classes of avoidable injuries. Participating providers would establish a “patient safety infrastructure” to identify and avoid injuries, and would be immune from suit within that infrastructure. The federal government would provide reinsurance on a shared-cost basis to participating providers.
- Statewide administrative resolution, a system in which all providers would participate in a state-sponsored administrative system established to compensate patients who suffer avoidable injuries. An administrative adjudication system would determine compensable damages, and providers would be immune from suit. The federal government would fund start-up costs for this system.

Sage also suggested that malpractice reform might encompass employer initiatives such as workers compensation-style compromises, potentially using ERISA as the enabling statute. However, he noted that such an initiative might be hampered by an ongoing tension between malpractice reform and general business tort reform

Medicare, Sage said, would be an obvious leader for reform: Medicare beneficiaries fare worst in the current system. As retirees, they suffer relatively little income loss. In general, they are relatively passive as patients and unlikely to sue. And they cannot wait many years for case resolution. The program’s system of Administrative Law Judges (ALJ) is an obvious vehicle for administrative resolution of claims, he said, and such a system could be linked closely to the program’s interest in patient safety, pay for performance, and other emerging quality initiatives. He imagined the development of other types of pilot programs that might include an “earn in” for providers with low error rates, subsidizing their malpractice insurance. He also called for a change in “tort politics” to foster a more creative environment for productive reform.

CREATING COVENANTS TO HEAL HEALTH CARE

Glenna Crooks, Strategic Health Policy International

After leaving Washington, Glenna Crooks said she began discovering that more health care debates were being decided by politics, which is hardwired for conflict. She decided she didn’t want to be part of politics, she wanted to be part of the solution.

Crooks stated that in every culture we know of there are two gifts from God(s): law and the healing arts. Healing was a gift of the divine that was transferred to individuals through a healer. Law deals with how we deal with the fellow man.

In contracts, everything presupposes that the other party will fail. In contrast, covenants don’t end. These are agreements between parties such as kings and subjects, husbands and wives, and healers and patients. In covenants, God acts a witness to the promises you make to each other. You state that if I do this, may good come to me; if not, then let God punish me. In health care we’ve combined contracts and covenants.

There are two types of covenants: a covenant of grant and a covenant of obligation. A covenant of grant is one in which the other party doesn't have to do anything in return. A covenant of obligation has defined responsibilities for each party.

The Hippocratic Oath was a covenant between healers and other healers, and also between healers and their patients. By taking the Hippocratic Oath, healers entered into a covenant of obligation with other healers. The Hippocratic Oath is also a covenant of grant to their patients, with the healers granting the patients their health and healing. Later on, Maimonides crafted a new oath that added on a covenant of obligation between healers and patients. This covenant required patients to participate in their healing by complying with the advice of their healers. Crooks stated that both of these covenants fall short because they fail to include the community in the covenant. She outlined her prescription for the health care system: a renewed covenant of obligation between healers, patients and communities.

The first part of her prescription is a renewed covenant of obligation among healers. She stated that in order for there to be progress, it will take all of us working together to move things forward. In addition to the traditional healers, such as physicians, nurses, and pharmacists, there are other healers in today's system who should commit to the covenant of healers to care for their patients. These new players include health insurance companies, pharmaceutical representatives, and the media. All of these players need to recognize and accept their responsibility to act ethically and morally and in the best interest of the patients.

The second part would bring patients in under a covenant of obligation. Crooks stated that we don't want patients to be dependent on the healers. Under a covenant of obligation, patients would be responsible for being better managers of their own health. For instance, patients should be required to follow the advice of their physicians. She stated that we need to move to a point where healers and patients can become interdependent.

The third part of her plan would bring in communities, asking that they better support healing through funding and better policy choices for safe and healthy communities. For instance, she stated that we can't tell poor individuals to eat well if they can't access good and healthy food. Similarly, we can't tell people to exercise if they don't have communities where it is safe to walk outside.

Crooks said that the reception from her message so far has been positive. She asked the audience to consider that there is another way for health care if we think about all of the players involved. She called it moving from a patient-centered approach to a health-centered approach.

CONSUMER-DRIVEN HEALTH PLANS: POTENTIAL, PITFALLS, AND POLICY ISSUES

Stephen Parente, University of Minnesota

Mr. Parente began by summarizing preliminary findings from a study of six employers that he is conducting in collaboration with Roger Feldman and Jon Christianson at the University of Minnesota. These employers represented 250,000 covered lives in 50 states; many had at least 5 percent take-up of a consumer-driven health plan option (CDHP) in the first year that it was offered. Based on human resources data and claims data, they have found that 2002 mean total

(employer and employee) expenditures in CDHP plans (\$8,149) were less than in PPO plans (\$8,378) but greater than in POS plans (\$7,198). The CDHP plans do not have the lowest use across all plans. They experienced higher hospital admission rates and higher cost for hospital care—reflecting, he argued, pent-up demand for elective procedures and provider pricing—but the lowest cost for prescription drugs, apparently related to much lower cost per filled prescription. Parente and his colleagues observed no “dramatic” differences in use of physician services or filled prescriptions among plan types, and concluded that there was no obvious problem of access to care in the CDHPs they studied.

To explore the take-up of CDHPs related to health savings accounts (HSAs) in the individual market, Parente and his colleagues developed an analysis of Medical Expenditure Panel Survey (MEPS) data, CDHP claims data, and HSA plan designs and premiums derived from ehealthinsurance.com. They concluded that the take-up rate might be higher than for health reimbursement accounts (HRAs), due to much lower premiums for CDHPs than for conventional PPOs. Without explicit subsidies, they estimated that about 10 million people might enroll in HSAs as authorized in the 2003 Medicare Modernization Act (MMA).

Parente observed that there are diminishing returns to subsidies to induce coverage among people who are now uninsured. Nevertheless, a hypothetical, targeted tax subsidy for HSAs might increase coverage among the persons who are now uninsured from 4 million to 14 million. Parente concluded by noting that the future of HSA/CDHPs will depend critically on benefit design—including premium levels, coinsurance, and the gap between enrollees’ HSA balances and the CDHP deductible.

John Bertko, Humana, Inc.

Bertko provided an actuary’s perspective on CDHPs and addressed how experience might vary among companies that offer them as an employee plan option. He reviewed the measurement issues that complicate comparative analysis of CDHP experience—including differences or changes in benefit richness, differences in patient compliance with treatment and/or drug regimens, seasonality of claims experience, selection bias, differences/changes in demographics, and differences in “credible experience” related to the timing of CDHP implementation. Bertko noted also that most experience with CDHPs is for large employers, with 100 to 500,000 employees, who offer a CDHP as a “slice” option, but rarely convert to a single (full replacement) CDHP. He concluded that the most important comparison is for the “whole employer group or system,” not comparison of experience within each option.

Bertko presented Humana’s own experience with two CDHP options (with deductibles of \$1,000 and \$2,000, respectively, the latter rising to \$2,500 in the second year of implementation). He compared that experience to the company’s experience with its HMO, tiered PPO, and standard PPO options. Between July 2001 and June 2002, Humana’s cost experience per member per month for the CDHPs was much lower (\$39 and \$51, respectively) than for the other plans (\$110-\$141). Overall, he estimated that Humana saved \$2.1 million in the first year of implementation, of which \$1.4 million was related to “increased consumerism”—appropriate behavior in selecting plans and utilizing resources within the plan.

Bertko noted that among “Smart Suite” enrollees (in the CDHP options) out-of-pocket expenditures among the highest-cost enrollees (the 5 to 6 percent with eligible charges above

\$10,000) fell in the second year of enrollment. Across all Smart Suite enrollees, inpatient utilization dropped 18 percent (compared to -1 percent in the market), physician service use increased less than the market (+10 percent, compared to +11 percent). Overall medical expenditures increased just 5 percent (compared to 13 percent in the market), and prescription drug use was flat (compared to +4 percent in the market). He noted that as of December 2004, Humana had enrolled 208 client employers in Smart Product plans; across these employers (representing 128,000 members in 124 groups, with 7 to 12 months of data), the Smart Product annualized cost trend has been just 4.9 percent. He conceded it is too soon to draw final conclusions from this experience, but noted that the implications for CDHPs are promising.

Shoshanna Sofaer, School of Public Affairs, Baruch College

Dr. Sofaer addressed the information and decision support that consumers will need for CDHPs to meet their objective—chiefly, to change consumer behavior in order to increase the value of coverage for both purchasers and consumers. She defined value as the amount of appropriate and effective health care received per dollar spent. CDHPs, she noted, create incentives for consumers to be more cost- and value-conscious, and attempt to provide the information necessary to help consumers make prudent decisions. In expecting consumers to enroll in CDHPs, she said, we are asking them to be less risk-averse in their choice of health care coverage, accepting higher deductibles for lower premiums and a less restricted network of providers. The widely shared concern about favorable selection into CDHPs (and adverse selection in more comprehensive plans), she said, is reducible to a simple question: “Why would a sensible person with a serious illness make this choice?”

If consumers are to make rational health-related choices—using the services they need and only those services, choosing high-value care and providers, and moving toward healthier lifestyles—they need information and support. Specifically, they need to understand their health care coverage options and how they work (compared to each other), how the CDHP works, their MSA account balance relative to their financial exposure, and the relative cost and value of treatment options and providers. They also need decision support to help in making behavioral and lifestyle changes, and to understand the implications of their coverage choices, when they do and do not need care, and when they can rely on self-care.

However, based on preliminary conclusions from her own research with Judith Hibbard, Sofaer said they get only some of this information and support. Specifically, they receive well-designed information on how the CDHP works and their account status, and in some plans they receive personalized decision support around the need for services and self-care. But comparative quality information on hospitals is limited, and such information for other types of providers is very rare. Consumers also generally do not get evidence about the value of alternative treatments or medications, comparative information on the cost or price of providers or treatments, or proactive support for healthy and prudent behaviors—such as reminders about preventive care; disease management support; or advice about the use of less costly alternative medications, providers, or treatments.

In short, Sofaer said, CDHP strategy appears to focus on insurance choices, not the use of care. As a result, they seem unlikely to influence the most significant sources of health care costs and may deter consumers with significant health problems from enrolling. In fact, she observed, the kind of information needed to help people make health care decisions—information on

comparative quality and cost or price—is typically not available. Moreover, valid cost or price information may never be available, since “price is determined as much by who is buying as what is being sold by whom.” Moreover, she said, it is not clear that purchasers are pushing CDHPs to improve the information and decision support they provide.

Sofaer concluded by reviewing other issues that arise in the delivery of consumer information and decision support. In particular, she observed that the information available to CDHP enrollees presumes that they are literate, computer literate, English-speaking, and fairly educated. Implicitly, those who are some or none of these are disadvantaged. Considering the challenges of providing the information and decision support needed to widely change consumer behavior, she said, it is essential to evaluate whether CDHPs can be a solution to address the cost of health care overall, or whether they can address costs only for some purchasers and consumers? If CDHPs are widely adopted with the information and decision support now available, she noted the potential for greater disparities in health care quality and health status.

MEDICARE COVERAGE DECISIONS: BALANCING COMPETING DEMANDS

This session focused on the process to determine what benefits are covered under Medicare.

Steve Phurrough, CMS

Phurrough, who chaired the session, began by discussing the steps involved in developing Medicare reimbursement. First, there has to be regulatory approval (e.g., a drug has to be approved by the FDA). Second, Congress has to make a benefit category determination (e.g., hospital services are covered by Medicare). Third, a coverage determination must be made and legal authority requires that the service be “reasonable and necessary” (Phurrough said this was CMS’ mantra). Fourth is coding and then payment can occur.

There are two ways in which coverage determinations can be made. First, local hired contractors for CMS make decisions for services that are not covered by existing national determination; this represents 90 percent of coverage determinations. Second, a national coverage determination (NCD) can be made, and this happens in about 10 percent of coverage determinations. From the start of the NCD process, CMS has 6 months to reach a final decision on a coverage determination (note that the process sometimes takes longer). There is a repeal and reconsideration process as well.

CMS will often conduct an NCD if there are differences in local determinations. CMS tries to base their determinations on evidence-based medicine, and looks specifically for studies that are generalizable to the Medicare population (they prefer clinical studies that have included or focused on elderly patients for example).

Ultimately, one of four different coverage decisions may be made by CMS: national coverage, national noncoverage, no national coverage decision made (in which cases decisions are left to local contractors), and coverage in data collection systems (services are provided as part of a clinical trial or similar).

Peter Neumann, Harvard University

Dr. Neumann focused on CMS' performance on national coverage decisions (NCDs) from 1999-2003. He began by presenting a brief history of the NCD process. In 1989, regulation that proposed cost-effectiveness analysis be used for national coverage decisions was very controversial and was eventually withdrawn. In 1998, CMS created the Medicare Coverage Advisory Committee, which it sometimes uses to make NCDs. Between 1999 and 2003, CMS' process for NCDs became more public and decisions are now posted on the web. Medicare generally has reviewed 10-15 new medical technologies each year for NCD for the past several years.

Neumann noted that there's a lot at stake financially with NCDs and provided some examples of the costs of coverage decisions (recently approved PET scans for Alzheimer's Disease cost Medicare \$1 billion annually).

In his recent research, Neumann classified evidence for each NCD as good (consistent results from well-designed studies), fair (strength of evidence is limited), and poor (very limited evidence). Of the 69 NCDs reviewed, Neumann found that most of the time, the evidence was not strong (16% of cases had good evidence, 42% had fair, 33% had poor and 9% could not be determined). However, there was consistency between the level of evidence and the coverage decision. When the evidence was good, the benefit was always covered. In the case of fair evidence, the benefit was covered most of the time. Finally, for most procedures with poor evidence, there was no national coverage most of the time. When a procedure is covered, it is almost always covered with conditions (i.e., only for certain patients or in certain types of facilities).

Neumann has found that Medicare Coverage Advisory Committee (MCAC) involvement in coverage decisions tended to lengthen the review times. Time frames for review were shortest when MCAC was not involved and when there was no health technology assessment (HTA). Those procedures that included both MCAC and HTA had the longest review times. There is some evidence that MCAC is assigned to harder coverage decisions, which is one reason they are associated with longer review times.

Neumann summarized that Medicare NCDs are now transparent decisions. These decisions are consistent with the evidence, though the quality of evidence is often fair or poor. CMS does not meet its target time frame of 6 months for review, which may suggest that CMS needs additional financial resources. Other policy implications of this work include the fact that better evidence is needed, formal criteria for coverage may be worth revisiting, and the fact that there may be some role for cost-effectiveness analysis (not as a yes/no decision process, but at least as a guide).

Examples of recent cost-effectiveness analysis ratios include: \$500,000 to \$1.4 million per quality-adjusted life year (QALY) for left ventricular assistance devices and \$500,000 per QALY for a PET scan for Alzheimer's Disease. Neumann notes that these are very expensive ways to buy health in cost-effectiveness terms. See www.hsph.harvard.edu/cearegistry for more information.

Susan Bartlett Foote, University of Minnesota

Dr. Foote began by noting that coverage determination was a “stealth issue” for a long time, but now people understand the importance of it. Dr. Foote’s research has focused on local coverage determinations (LCDs), which are much less studied than NCDs. Foote did a survey of contractor medical directors of CMS fiscal intermediaries and carriers, analyzed 6,900 LCDs, and did case studies to examine aggregate policies. Foote noted that local contractors got authority to make coverage policy for a major public program because of an “accident of history”; it basically evolved out of a need of contractors to inform providers about what is covered by Medicare.

Foote stated that contractor consolidation has occurred over time. Most states have a carrier that covers multiple states, and the distribution of carriers across states generally is not regional or otherwise systematic. Contractors vary greatly in terms of productivity; some have lots of policies on their books, others don’t. Most contractors reported relying on scientific journals, but often fail to cite even one journal article in making a case for new technology. Some contractors never develop policy but instead apparently make decisions on a case-by-case basis.

Foote found a lot of variation across contractors in utilization management decisions, and variation suggests quality of care issues. She is conducting ongoing work to look at the link between policies and claims.

James Cross, Aetna

Cross began by stating that, in developing clinical policy development, Aetna aims for “objective, clinically supported, and defensible determinations.” Unlike Medicare, they are not legislatively driven, but rather contract driven. Their contracts exclude “experimental and investigational” medicine, and covered care must be “medically necessary” care (for which Aetna has a specific definition).

Cross noted that everyone struggles with the quality of evidence, and most of medicine is not evidence-based.

Cross has a staff of 5 people that review coverage decisions. In order for something to be reviewed, it must be new, expensive, and must affect members. As part of the review, Aetna will do a Medline search, look at Blue Cross/Blue Shield assessments, and other sources. In some cases, they rely on specialty panel guidelines when no clinical trials have been conducted or the trials simply are too small.

Aetna’s clinical policy council meets every two weeks for two hours. They review 600 cases per year. Reviews must be fully disclosed on the Internet and transparent to their members, similar to CMS.

As far as the role of Medicare policy for Aetna, Cross noted that Medicare is the largest payer in the country, so Aetna follows Medicare at least indirectly. So CMS influences the standard in the industry. Aetna has Medicare HMO and PPO members, and in that case, has to follow Medicare clinical policy. Cross noted that Aetna and CMS differ in some cases. For

example, Aetna does not cover PET scans for Alzheimer's Disease, but have covered some things sooner than CMS did (e.g., fecal occult blood testing).

Aetna produces a standards table that shows covered services across all policies and processing systems. This makes decision-making consistent and allows providers to see exactly what's covered. All clinical policies are updated on an annual basis.

Question and Answer

During the question-and-answer portion, Foote noted that Medicare could be more creative in using the regional system to test different technologies. Cross noted that medical devices receive nowhere near the rigor of the FDA process for drugs.

CHILD OBESITY: INNOVATIVE STATE PROGRAMS

James Marks, The Robert Wood Johnson Foundation

According to Marks, we are in the midst of an epidemic that is unprecedented in its scale and scope. In the past three decades, obesity has tripled among 9- to 11-year-olds. Children are now being diagnosed with conditions that only used to be seen in adults. The problem has only become obvious in the last three years.

Marks said that the increase in childhood obesity is not because of changes in genetics, but it is because of changes in our society and environment. Healthy choices have been made harder to make. For children in particular, society and environment are important because others tend to make the decisions that influence the environment they live in.

In 1969, one half of children walked or biked to school. Now, nine-in-ten are driven, either by their parents or on a bus. Among those within a mile of their school, 75 percent are driven. The reason, according to Marks, is because our communities have been designed around cars.

There is also less activity for children in schools. In just one state is physical activity required every day in all grades. As schools have moved toward contracting for food services, cafeterias look more like food courts and vending machines are more prevalent.

In poor neighborhoods, Marks noted that there are fewer supermarkets, making it harder for parents who are trying to do the right things. Good choices are more expensive and quality tends to be lacking in poor areas. Also, many neighborhoods don't have safe places to exercise.

RTI and the Centers for Disease Control estimated that obesity costs the United States \$93 million per year, with half of those costs being borne by public payers. In the District of Columbia, they estimated that obesity costs each person an additional \$660 per year. These cost figures are mostly due to obesity among adults who weren't obese as children.

Five years ago, goals were set for Healthy People 2010. Marks said that the obesity epidemic is the single biggest force taking us in the opposite direction from those goals. However, there is some good news. It is unprecedented for the public health community and the

media to give the level of attention it has given to obesity to a condition that is a slowly developing condition.

Personal choice and personal responsibility are only part of the story, according to Marks. Society must make healthier choices easier to choose. He sees the fact that water is the fastest growing product market in the soft drink industry as proof that society can make healthful choices more attractive.

Overall, Marks said that we don't yet know what the most effective approaches to combating childhood obesity are. The Robert Wood Johnson Foundation is now sponsoring a series of evaluations of strategies that have been adopted widely. But, he noted, society can't wait for science to catch up and for all the results of the evaluations to come out. We must act on the best available evidence, not the best possible.

Joseph Thompson, Director, Arkansas Center for Health Improvement

Joseph Thompson discussed the Arkansas Child and Adolescent Obesity Initiative. Arkansas passed the legislation (Act 1220) in 2003 to "improve the health of the next generation." The Act is aimed at improving the environment, engaging the community, and creating awareness of child obesity issues.

Elements of the Child and Adolescent Obesity Initiative include:

- Eliminating all vending machines in elementary schools.
- Requiring professional education of all cafeteria workers.
- Public disclosure of "pouring contracts." Pouring contracts are contracts that schools have with soft drink companies to only serve the company's products at the school.
- Requiring parent advisory committees at each school district.
- Requiring child health advisory committees.
- Requiring an annual Body Mass Index (BMI) assessment on every child every year.
- Creating the Arkansas Center for Health Improvement.

The Arkansas Center for Health Improvement was charged with implementing the annual BMI assessments with no dedicated funding. They developed the protocol and dealt with privacy concerns. In many cases, schools had to purchase scales. Arkansas schools completed the first year of assessments last year. Ninety-one percent of schools in the state returned BMI forms and 84 percent of school districts had complete compliance. According to Thompson, over 430,000 child health reports were mailed out to children's homes.

Analyzing the data from the BMI assessments, Thompson says they found that 39 percent of students were in the two heaviest categories. There were significant ethnic differences. Among African Americans, 43 percent of children were in the two heaviest categories. For Hispanic

children, 48 percent were in the two heaviest categories. Among whites, the number was 38 percent.

The Arkansas Center for Health Improvement is now working with Medicaid to link clinical services to those areas with the worst assessments. In the second year of the assessments, the Center will be conducting continuing medical education for physicians about screening for child obesity and completing community, school district, and individual school reports.

Also as part of the Initiative, the University of Arkansas School of Public Health is doing some evaluation activities to monitor the effect of the Initiative. They recently released results from their baseline surveys of schools, children, and parents. Among their findings:

- 80 percent of schools have an exclusive pouring contract.
- More than 60 percent of schools use food sales as a fund raiser.
- 10 percent of adolescents spend more than five hours a day watching TV or playing video games.
- More than 50 percent of adolescents eat dinner at least once a week in front of the TV.
- 75 percent of parents report attempts to limit the junk food in the house.
- 63 percent of parents report trying to change their family to a healthier diet.
- 90 percent of parents and 80 percent of children were supportive of making changes in vending machine contents.

Next steps include making sure the 2005 Arkansas General Assembly doesn't repeal the law and some key Board of Education decisions. Thompson said that while there have been some challenges to the Initiative, he thinks there is enough support to continue. They are also working on expanding awareness of the problem and supporting the local school district parent advisory committees.

Victor Colman, Washington State Department of Health

Victor Colman suggests that there is a rare opportunity in place to address obesity as a problem given the amount of interest. He noted, however, that if we limit the discussion to children, then solutions will all be school-based and this is really a much bigger issue.

Washington state developed the Nutrition and Physical Activity Plan in the spring of 2003. This plan has been the major springboard to a lot of the activities in the state. The goal has been to make the healthy choice the easy choice.

Colman said that a number of coalitions have sprung up across the state to address nutrition and physical activity issues since spring 2003. Overall, he said coalitions are an effective way to change policy, but there are some limitations. First, he said coalitions tend to focus on activities

that aren't necessarily linked to a broader strategic plan. Second, coalitions need to be more performance-based. Also, coalitions tend to shy away from policy development. Finally, coalitions reflect parochial interests, for instance nutrition versus activity.

Given these limitations of coalitions, Colman developed the Nutrition and Physical Activity Policy Leadership Group. The point of this group is to develop a strategic vision and decide what policy shifts need to take place in order to get to that vision. The Policy Leadership Group includes both public and private partners. The challenge, according to Colman, was bringing in groups that the Department of Health doesn't usually work with, for instance the food services industry, the Department of Transportation, and the Parks and Recreation Department.

One of the activities the Department of Health is sponsoring is STEPS: Steps to a healthier Washington. The program gives grants to local organizations that want to do something about nutrition or physical activity. The grants are supposed to be used for policy change. Colman said that many of the programs are using the grants to train people at the local level in policy development.

Colman noted a number of lessons that have been learned. First, the scattered approach isn't necessarily efficient. Local activism is needed to make changes at all levels. Coalition building is also important.

Colman also summarized some of the challenges he has seen. Best practices are still emerging to address obesity. There needs to be some sort of critical mass of funding for real change to take place. He also said preventive care still isn't legitimized in the health care world. Colman said that changing the social environment is a political activity, and the public sector has a bona fide role in policy development, but is often unwilling to participate. Finally, he said that the focus is still geared to individuals and families.

In conclusion, Colman said that there has been a clear commitment by the public health world to be involved in activities to reduce childhood obesity, but public health also needs to invite to the table and go to new sectors. He also said states need greater resources for program evaluation activities and to build sustainable programs. Finally, he said states can learn a lot from the tobacco control efforts.

Dr. Alex Kelter, Office of State Public Health Officer, California Department of Health Services

Dr. Kelter discussed some of the initiatives California has in place to reduce childhood obesity. He currently leads a Department of Health Services action team on child obesity.

Dr. Kelter stated that California is the birthplace of the 5 A Day campaign to increase fruit and vegetable intake. He noted that the program is really about nutrition education among food stamp recipients, but he believes that it has carried over to non-food stamp participants as well. He said that as a result of the campaign, there has been a bit of an increase in activity among California children in the last few years.

Another initiative was Senate Bill 19. Under this legislation, the state set nutrition standards for all elementary schools in the state. Under the standards, not more than 35 percent of calories

in a school lunch can come from fat. Also, elementary schools are only allowed to serve water, milk, and fruit juice. At middle schools, only water, milk, fruit juice, and electrolyte replacement drinks may be served from one half hour before school to one half hour after school.

California is also a major promoter of “Walk to School Week.” The state has also taken advantage of Safe Routes to School legislation that allows the state to access federal money for physical improvements to local neighborhoods that make it easier for children to walk or ride their bike to school.

Dr. Kelter noted that there were a variety of programs addressing individual aspects of nutrition and activity across the Department of Health Services. All of those programs have now been brought together through the DHS Action Team. The Action Team is comprised of 31 individuals from 22 different parts of the Department. Representatives come from areas such as injury control, rural health, WIC, maternal and child health, cancer control, drinking water, Medi-Cal, and food safety. The Action Team is focused on both activity and nutrition. The ultimate goal is to shift the BMI curve to the left and to make daily activity a part of individuals’ routines, not just an add-on activity.

For fiscal years 2005/06, DHS received \$6 million from the state general fund for an Obesity Initiative. The legislation includes the establishment of a coordinating office in the Office of the Public Health Officer. The \$6 million includes money for:

- Community Action Grants to local community organizations that want to do something to increase activity or improve nutrition. One of the areas that Maria Shriver has been committed to improving, for instance, is the development of edible school yards, with the help of the Department of Agriculture.
- Health Care Quality Improvement. The Department is first focusing on activities geared toward children in Medicaid managed care organizations. The activities include collaboration between providers, hospitals, communities, and local health departments. Some of the components of the program include breastfeeding promotion, preventive services, and treatment for overweight children.
- Tracking and Evaluation. The Department will look at what new areas should be tracked. For instance, they may want to track the number of hours of junk food ads that are seen by children or the number of supermarkets in different local areas.
- Public Relations and Communications
- Worksite Wellness

Additionally, Governor Schwarzenegger has committed to lead a Governor’s Summit on Obesity Prevention later in the year. The summit will bring in 100 private and public sector leaders to think differently and promote shared responsibility. Invitees include representatives from the weight loss industry, public safety, builders, celebrities, the Department of Education, corporate entities, and the food industry. DHS is also conducting three “listening sessions” with representatives from public health agencies to get their thoughts. Dr. Kelter said that from the

summit they expect to create a sense of urgency for dealing with the problem and to create a roadmap for California to address the problem.

One of the important lessons, according to Dr. Kelter, has been that you can't have too many partners. He also said that one of the most central issues to the problem is the lack of affordable housing where the jobs are. Because there isn't enough housing, people commute hours per day and spend time in cars. Another key issue, he said, is pricing and marketing healthy foods.

CRITICAL ISSUES FOR STATES

Governor Kathleen Sebelius (D-Kansas)

Governor Sebelius addressed the conference describing Kansas's perspective on the problem of the uninsured and on working with the Medicaid and SCHIP programs. Kansas, she noted, is not only in the middle of the country, but also "in the middle of spectrum on cost and access issues." The state has weathered difficult economic times, and is recovering—but "the recovery is fragile," she said, and the state continues to rely on shifting funds to fill gaps, cutting where it can.

She said Kansas—and most other states—are in a "quiet crisis" in health care, affecting families, payers, and providers. "None feel we're headed in the right direction." She observed that it is time to think about how to refashion health care in Kansas and throughout the country to control cost. Over the past 20 years, she said, the states have become the insurer of last resort and "major players" in addressing health care problems. The growing numbers of uninsured, she asserted, are "a symptom of an out-of-control, irrational system of health care." In Kansas, health care is 22 percent of the state budget, with state government having become the largest purchaser of health care in the state.

Governor Sebelius is the first governor of Kansas to establish an office of health policy attached to the governor's office. She noted that 30 percent of health care expenditures in Kansas are associated with administrative cost: "clerks filling out paper forms, confirming patients for coverage, and resolving claims issues." To reduce administrative costs, she has appointed a Health Care Commission charged with developing strategies to standardize provider credentialing forms and health insurance provider cards. The commission also will investigate strategies to collect the power of state to leverage purchasing and move quality—incorporating Medicaid and administration of the State employee health plan in a common framework; and expand the insurance market for small businesses. Small businesses and farm families dominate Kansas, she said. Two thirds of uninsured adults earn more than 200 percent of the federal poverty level, but work for small employers that either do not offer coverage or require a large employee contribution for coverage. Kansas's insurance commissioner is exploring the potential for stop-loss coverage or reinsurance to stabilize the small-group market.

Governor Sebelius described Medicaid as a "double edged sword." Medicaid helps the states to provide care to 50 million Americans, she said, but the cost increases seem unstoppable. "The spiral of costs cannot continue," she said, though it is the very success of the Medicaid program—rising enrollment—that drives its costs.

“Without Medicaid,” she said, “the number of uninsured would be catastrophic.” She observed that one-third of children in Kansas are enrolled in Medicaid or SCHIP. However, cost increases in these programs are much less than in private insurance: per member per month cost increases in Medicaid and SCHIP have been just 4 percent or less for mothers and children. The elderly and disabled, she said, are more costly, and their costs are rising faster. She observed that financing care for these populations had been “shifted to the states without discussion or dialogue.”

Meaningful reform of Medicaid, she said, must “take a long-term view,” recognizing the aging of the baby boom population. It is critical that the funds needed to address problems in Medicare and Medicaid be made available, she said, and not as cap grants that “leave grandparents competing with grandchildren.” Meaningful reform, she stated, should “start with ‘do no harm’: the solution cannot be to balance the budget on the backs of the most vulnerable.”

Governor Sebelius suggested that it would be useful to start Medicaid reform with a dialogue about cost drivers and costly populations. She said that she is cautious about embracing a market-based approach, especially for vulnerable populations. “Health care isn’t a real market, and it’s certainly not an efficient market,” she said. “Problems of overuse should not be solved by unraveling systems in place.”

She also observed that the health care system is “information-deprived.” “Useful information for consumers is in short supply,” she said, “and the health care market operates with a remarkable lack of transparency.” She noted that improvements in information will require “a huge push and a huge investment.”

For the present, the notion of shared responsibility between the federal and state governments is in “serious jeopardy,” she said. The claw-back provision in the Medicare Modernization Act (MMA) “forces state legislators to be revenue-raising agents for the federal government.”¹

Governor Sebelius proposed a series of ideas to guide Medicaid reform, including:

- A national, comprehensive approach to financing long-term care
- Additional flexibility in Medicaid’s benefit package and use of Medicaid funds
- Flexibility to address problems on regional basis, not restricted to individual states
- Public and private-sector strategies to cover the working poor

¹ In extending prescription drug coverage to Medicare beneficiaries, the Medicare Modernization Act (MMA) requires states to help finance the new benefit via a provision popularly known as a “clawback” (called in statute a “phased-down State contribution”). The clawback is a monthly payment to be made by each state to the federal Medicare program beginning in January 2006. The amount of each state’s payment roughly reflects the expenditures of its own funds that the state would make if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual eligibles—i.e., low-income elderly or disabled individuals who are enrolled in both Medicare and Medicaid. The state clawback payments to the federal government are projected to be \$6 billion in 2006, rising to \$15 billion in 2013 (<http://www.kff.org/medicaid/7118a.cfm>, accessed February 16, 2005).

- Buy-ins to Medicare

In addition, she said, Medicaid and SCHIP rules should enable children older than age 18 to enroll. And finally, she said, the states need to find ways to learn from one another: the Healthy New York program, for example, could be replicated, “but the process of replication is cumbersome.”²

Governor Sebelius also pointed out the risks of doing nothing. The system “is moving rapidly toward different types of health care for different types of families,” she said. “The wealthy are doing well, and the poor will do well enough unless Medicaid is unraveled.” But the middle class, she said, is in jeopardy. “Cost sharing exceeds their resources,” having become a significant source of bankruptcy among families with insurance.

The states can play key roles, she said, especially in crafting incentives for providers to follow scientific medical protocols and in developing information and greater transparency in the system. However, like other states, Kansas is working on these problems in the context of short-term Medicaid crises. The states need allies at the federal level, she said, both to head off “a looming crisis in health care” and to provide quality that matches the “staggering level of resources” that we spend on health care nationwide.

THE FUTURE OF ENTITLEMENTS: WHEN PUSH COMES TO SHOVE

Jack Meyer, Economic and Social Research Institute

Meyer, who chaired the session, stated that the current system is based in centuries-old traditions of financing and delivery, colliding with the information age. The country faces looming challenges in health care that are well captured in Henry Aaron’s book *Coping with Methuselah*, according to Meyer. There has been a 30-year increase in life expectancy in the last 100 years, stem cell research is occurring, and we are mapping the human genome. These developments lead to wonderful benefits and substantial costs. Meyer highlighted the need to modernize social contracts in ways that are fair and efficient. Changes made to federal entitlement programs will increasingly affect health care overall as the nation ages.

Alice Rivlin, The Brookings Institution

Dr. Rivlin gave the big-picture view of federal budget prospects. She stated that the federal government is spending a half-trillion dollars more than its revenues. Deficits will continue to grow, due to increased longevity and the rising cost of health care, unless we begin to spend less

² Healthy NY is a New York state program designed to encourage employers with 50 or fewer employees to offer health insurance to their employees, dependents, and other qualified individuals. Healthy NY is also available to eligible working uninsured individuals including sole proprietors. The program creates standardized health insurance benefit packages that are offered by all health maintenance organizations (HMOs) in New York state. These packages are made more affordable through State sponsorship, so that more uninsured small employers and uninsured employed individuals are able to purchase health insurance coverage ([http://www.ins.state.ny.us/Web site2/hny/english/hny.htm](http://www.ins.state.ny.us/Web%20site2/hny/english/hny.htm), accessed February 16, 2005).

or tax more. It's a deteriorating big picture, Rivlin said. Medical care is increasingly effective but increasingly expensive.

The federal deficit for FY04 was \$412 billion. In FY05, it is likely to be \$450 billion, and would be higher, except that the Social Security surplus and Medicare trust fund offset part of the deficit. Rivlin stated that there's not much hope of getting the budget back in balance in four years, or even 10 years. Moreover, the 10-year window gives a misleadingly optimistic picture, as dismal as it is. As the Social Security trust fund starts to draw down, the net deficit accelerates as a percent of gross domestic product (GDP).

While the federal deficit also is related to federal spending, the dismal outlook is not due to heightened spending, according to Rivlin. Tax revenues have dropped below the historic average and are likely to stay there. Spending on the Iraq war has increased the defense budget but is still a relatively small share of GDP.

Looking beyond the 10-year window, the aging population and the cost of medical care will result in enormous budget pressure. Expenditures for Medicaid, Social Security, and Medicare will rise from 9 percent to 18 percent of GDP between 2010 and 2050, and those figures are based on moderate to conservative assumptions about growth in medical care prices (i.e., less than half of historic rates).

Rudolph Penner, The Urban Institute

Penner noted that program costs for the elderly (Social Security, Medicare and Medicaid) are now 8 percent of GDP but will rise rapidly in the next decade. Trends haven't much changed over the past 50 years, so why can we not continue? He stated that we actually did not finance expenditure growth over past 30 years. We came close to balancing budget in 1950s and 1960s, but financed less than half of the increase in costs—some through deficit, some from secular decline in defense spending (which dropped from 10 percent of GDP after the Korean war to 4 percent now). If programs are not reformed significantly, taxes will have to increase by 30 to 50 percent, other spending will have to decline dramatically, or deficits will rise to unacceptably high levels.

Penner pondered why financial markets are so "happy" given the pending fiscal crisis of the United States, noting that other countries and financial organizations give the U.S. the highest possible credit rating. He thinks it reflects financial markets' confidence in western democracies' flexibility and transparent government. However, democracies not adept at dealing with special interest groups, and the elderly are the "most potent." Under some estimates, the national debt could pass 100 percent of the GDP in the 2020s.

Penner identified several "nonsolutions," as follows:

1. Grow our way out of problem. Faster economic growth would help, but it is not likely to be enough. At age 60, Social Security benefits are indexed by prices, not wages—encouraging faster growth in the demand for health care.

2. Immigration. Immigration is very important to the American economy, but “immigrants grow old, too.” The immigration rate would have to rise continually faster than the age of the labor force.

According to Penner, possible solutions include:

1. Getting people to work longer and pay longer into the system. In the 1950s, the average age for retirement was 68. Now people live longer and are less likely to have manual labor jobs but still retire earlier. Specifically, we could change benefit indexation or delay full receipt of benefits. There are ways to induce longer work, but there are political and institutional barriers to doing so.
2. Move from a pay-as-you-go to a funded system. This approach involves some pain, often called the “transition problem.” Workers must continue to support current retirees, and also prefund their own retirement. Penner suggested that moving toward a funded system can be done by government, by moving toward a system of individual accounts (which are not foolproof either). A well-designed system would have a high probability of increasing national saving quickly—and reducing consumption. This would be politically difficult.
3. Introduce means testing. Penner indicated that he and his wife get substantial Social Security benefits—which he enjoys but sees as a “weird” use of taxpayer money. Not everyone (i.e., very wealthy) should get Social Security.

Penner noted briefly that Australia pursued individual accounts, with a floor or base program that provided everyone with a minimum amount. Some people spent their individual accounts before they retired.

Alice Rivlin, The Brookings Institution (continued)

Alice Rivlin then spoke again, focusing now on proposals for Medicare and Medicaid. She noted that Social Security is a far easier problem to deal with than Medicare and Medicaid. Rivlin said that not everyone thinks Social Security needs to be forward funded, and getting from here to there would be “very expensive.” If individuals are allowed to divert contributions into private accounts, you must make up the loss of funds in some other way to finance current benefits. One approach is to do a little bit of benefit cut and a little bit of tax increase, as in 1983. Rivlin noted that the eventual shortfall of Social Security is less than 2 percent of GDP.

The real question though, according to Rivlin, is what to do about Medicare and Medicaid costs. The U.S. spends 15 percent of GDP on health care and we are not much healthier than countries that spend much less. We must follow all the avenues—quality, markets, information, financing reforms—and hope that future technology change will be cost saving, not cost-enhancing.

The choices for Medicaid are reducing eligibility, reimbursement rates (which Rivlin described as “practically fatal”), or pushing the costs to the states. However, there is really no latitude for decreasing benefits or payment rates. Many options tend to shift costs, but not resolve them. With Medicare, delaying age of eligibility is not a real option, Rivlin said. Again, most options shift costs, and don’t contain them.

The really big picture is that there are very large upward pressures on spending, and the big question is how to deal with it. Rivlin described some “extreme” options as follows:

1. Pare back the historic commitment to the elderly and low-income families drastically or expect states to pick up the bill.
2. Keep the commitment to medical spending but slash other spending. To do this, we would have to practically close down the rest of government.
3. Allow total government spending for health care to rise from 20 percent to 25-26 percent of GDP (like other countries) and consider a new tax base (national sales tax or VAT) for financing.

According to Rivlin, the country is veering back and forth between denial and hysteria. We must remember we are not alone; other countries are experiencing this problem, and the U.S. is not aging as fast as the Europeans or Japanese. The country has to decide how to use our resources in the face of these changes.

Question and Answer

Penner and Rivlin agreed that Social Security is the low-hanging fruit; researchers and policymakers don’t know as much about how to solve the Medicare and Medicaid crisis. When asked about how the current problem with Social Security compares to the problem in 1983, Rivlin indicated it is about the same in terms of magnitude. She reiterated that shifting from a pay-as-you-go system to one of individual accounts would be very expensive. Penner noted that the Social Security trust fund problem won’t arise until 2042. At that point, according to Rivlin, funds flowing into the (unreformed) system will only pay for two-thirds to three-quarters of benefits.

CONGRESSIONAL HEALTH POLICY AGENDA

Mark Hayes, Senate Finance Committee (Majority)

Hayes began by noting that Douglas Holtz-Eakin (CBO director) has said the federal cost of Medicare and Medicaid will eventually exceed the entire federal budget. Mandatory spending is growing much faster than the economy is growing. The budget committee will need to do some “heavy lifting” on how to achieve needed savings.

Hayes noted that there are several specific items on the agenda for the coming year. First, Medicaid is due for a hard look, but the Senate will not pursue “draconian measures” that simply pass all burden on to states. Second, quality of care is a major issue. Given MedPAC’s work on pay for performance and Mark McClellan’s commitment to this issue, Hayes thinks that the Senate will have the opportunity to move this forward. The final item is health care access. Hayes stated that there is a lot of synergy between access and the Medicaid issue. He expects a renewed look at tax credit policy.

Elizabeth Fowler, Senate Finance Committee (Minority)

Fowler identified the two big issues on the agenda as Medicaid reform and implementation of the Medicare Modernization Act (MMA). She said that Congress is not looking across the entire budget to find savings but rather only looking at health-related expenditures. Given that Medicaid helps the poorest of the poor, Congress must be careful with reform. HHS Secretary Leavitt has identified \$60 billion to be reduced in the Medicaid budget by eliminating fraud and abuse, spend down by the wealthy for long-term care, and overpayment for pharmaceuticals. Congress is hearing that Medicaid provides Cadillac coverage when it should provide Chevy coverage.

Fowler highlighted the fact that Medicaid is a countercyclical program. As many as 7.5 million people were added to Medicaid between 2001 and 2003 because of the recession. However, per capita cost growth in Medicaid is lower than private cost growth. Fowler stated that she didn’t want to give the impression that Medicaid doesn’t need to be reformed, but policymakers and others need to remember that it’s unlikely you can cut \$60 billion and not affect real people with real coverage issues.

Fowler noted that the MMA final rule was passed last week; subregulatory guidance has not yet been released. Democratic members of the Senate are concerned about several components of MMA, including the appeals standard, the formulary for Part D, the transition of dual eligibles, and what happens to Native Americans since tribes will not be able to pay the Part D premiums for their members.

Fowler reported that she is not hearing a lot on the uninsured this year except from a few members of the Senate. This is because of the budget deficit as well as a lack of consensus on how to handle the issue.

Other issues that members will be watching for are information technology and pay for performance (Fowler noted that some physicians prefer the term “pay for quality”). Medical errors and medical malpractice are not under the jurisdiction of the finance committee, though members will be watching those issues.

Dean Rosen, Office of the Senate Majority Leader

Rosen started by discussing President Bush’s State of the Union address (delivered the previous evening), describing it as an “extremely moving speech.” He noted the speech’s focus on domestic policy and said that it was not an anti-government message at all. Social Security

will face major problems 20 to 30 years from now; the Medicare and Medicaid numbers are much worse and will result in a crisis much sooner.

Rosen identified several “guideposts” for the next two years. The Senate will work on the President’s agenda as described in the State of the Union address (e.g., expanding health savings account options). Additionally, the Senate will introduce the S4 bill called the Healthy Americans Bill. This bill focuses on reducing costs, improving coverage, and improving care, and follows the recommendations of a Republican task force headed by Senator Frist. With regard to Medicaid reform, Rosen noted that the \$60 billion savings in Medicaid over the next 10 years (as stated by Secretary Leavitt) is about 2 percent of Medicaid spending.

Rosen stated that the Senate will also focus on patient safety, health savings accounts, safety net issues, and health care disparities.

Bridgett Taylor, House Ways and Means Committee (Majority)

Taylor started by mentioning payment for physicians, noting that physicians keep seeing reductions in Medicare payments. However, physicians need to be kept afloat so they will participate in the program. Medical errors and patient safety is another issue for the House; the House introduced, marked up, and passed a bill last session, but it didn’t get through mark up in the Senate. With regard to information technology, Taylor stated that the Senate is further along than the House on this issue.

Medicaid is a very important issue to the House. Taylor noted that important populations are covered under Medicaid, including poor children and pregnant women, the disabled, and those needing long-term care. Taylor thinks it’s important to remember that while Medicaid and Medicare are eating up the federal budget, health care costs are eating up family budgets too. If Congress cuts Medicaid and Medicare, there will be more uninsured and it will be a cycle. Taylor made reference to a recent article in *Health Affairs* on bankruptcies related to medical debt (<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.63>), noting that most individuals who declare bankruptcy actually have private insurance. Moreover, if cost sharing is considered as part of Medicaid reform, policymakers need to remember that when copayments increase, there is less compliance with doctors’ orders.

Taylor referenced Dean Rosen’s statement about the \$60 billion cut to Medicaid spending being only a 2 percent cut in Medicaid’s total budget; however, according to Taylor, the SCHIP program costs around that same amount of money, which provides a different perspective on the magnitude of the cut.

Taylor stated that one way to find cost savings would be to fix the prescription drug rebate in Medicaid, so Medicare would get a negotiated rate instead of pharmaceutical rates. While Secretary Leavitt has indicated that he wants to give states flexibility under Medicaid, Taylor stated that many disabled people are already using community-based care (which might be cost saving). Some of the proposed Medicaid reforms are like “taking away from Peter to pay Paul.”

Question and Answer

When asked about physician reimbursement issues under Medicaid, a Republican staffer responded that physician payment is a looming problem. There isn't emerging agreement about what to do with physician payment. The physician payment fix in MMA was the biggest cause of the large increase in Part B premiums.

The panel was asked about the probability that Medicare expand eligibility to the age 55-64 population in the next 10 years. A Democratic staffer stated that Senator Baucus supports this but it is not a very popular idea overall. A Republican staffer said that the chance was extremely slim on the Republican side.

When asked whether Congress will look creatively across the entire budget when considering the Medicaid budget, a Republican staffer stated that the Senate would look across programs. A Democratic staffer noted that CBO scores legislation for spending but not savings (so any projected savings are not considered in budgetary scoring).

Asked about the key components to effective long-term care policy, a Democratic staffer suggested that the House is looking at tax credits for caregivers, and increasing home- and community-based care for those for whom it is feasible. The staffer noted that long-term care insurance policies have become unaffordable and some Democrats think long-term care should be paid for like Medicare.

A Republican staffer noted that, with Medicaid's Section 1115 waivers, the Senate is concerned about transparency in the process; there is little congressional oversight and the Senate sees that as a problem.

When asked about where there is the greatest potential for consensus on Medicaid (or other health care) savings, a Republican staffer indicated more home- and community-based care, looking at asset tests and seeing if people are hiding assets to become eligible for Medicaid (specifically long-term care), and also possibly fixing the drug rebate in Medicare.

The panel was asked about opportunities for consensus on dealing with the uninsured, tax credits, HSAs, etc. A Democratic staffer responded that there is more consensus on who should be covered than how they should be covered. There is some consensus about those at the lowest end of the income scale. The staffer stated that Congress should look at the Trade Adjustment Assistance tax credit though, which has high administrative costs, but small levels of enrollment because premiums are out of reach even though they are highly subsidized.

When asked about coverage for children, a Republican staffer stated that children are a priority and SCHIP has been very successful. However, given the states' budget shortfalls, Congress needs to figure out how to get SCHIP on more solid footing.

In response to a question about prevention initiatives, a Republican staffer noted that the Medicare program has added various types of preventive care since the mid 1990s. CBO counts preventive care as a cost, not a savings, in part because the doctor finds other things when you go in for preventive care.

When asked whether Congress was going to do anything to control the price of pharmaceuticals, a Republican staffer responded that it's a question of global R&D and who's going to pay for it. The U.S. pays a huge share of global R&D. According to this staffer, we depend on the R&D pipeline to meet big challenges—creating new medicines for Alzheimer's, Parkinson's, etc.—and we have to be careful not to be short-sighted even though we won't see the after-effects for 20 years.

The panel was asked whether Congress would consider dropping optional items under Medicaid. A Democratic staffer stated that optional services are not really "optional" in the sense that they are very important services, such as prescription drugs, dental care, eyeglasses, etc.

John Iglehart, who chaired the session, asked the panel if Congress supports the type of Medicaid waiver that has been used in Utah (which provides minimal benefits to a large population group). A Democratic staffer said that Baucus has expressed a lot of concerns about the waiver program. The Utah waiver lowers the bar for coverage. Giving some people just a little bit of something isn't solving the problem of the uninsured. A Republican staffer noted that state budgets are being eaten up by Medicaid, and to the extent that we are concerned about that, waivers will continue. Through the waiver process, Medicaid has been reformed without federal standards. The federal government should step in and create some standards. A Democratic staffer stated that some think the administration is overstepping its statutory bounds with these waivers.

PAY FOR PERFORMANCE PROGRAMS

Dennis Scanlon, Pennsylvania State University

Dr. Scanlon, chair of the session, began by posing the question: Is pay for performance hype or hope? He stated that he wanted to be optimistic about pay for performance, but recognizes its many challenges. Scanlon noted that there are a large number of pay for performance initiatives, such as Medicare's Premier hospital demonstration project, Boeing's Hospital Safety Incentive Program, and Leapfrog, as well as a growing number of plans using tiered copayment structures for hospitals and physicians (so that consumers are encouraged to see higher quality providers through lower copayments). A compendium of pay for performance efforts are provided on Leapfrog's Web site at <http://ir.leapfroggroup.org/compendium/>. This session focuses exclusively on Bridges to Excellence (BTE).

Scanlon briefly discussed the fact that incentives are often not well aligned in health care. Intermediaries may or may not be taking on risk. From a skeptic's viewpoint, pay for performance may face the following obstacles: 1) even large employers may not have enough clout in specific markets, 2) financial incentives are not large enough relative to the costs of participating, 3) measures of quality are poor, 4) the necessary IT infrastructure is not in place to support pay for performance, and 5) pay for performance is just the latest in a line of employer initiatives.

Dale Whitney, United Parcel Service

Whitney started by saying that after the IOM report, employers felt they needed to become more engaged in the health care system. Employers participating in Bridges to Excellence (BTE) felt they needed to transform to a consumer-driven market because “it’s our responsibility as purchasers.” Employers in BTE also thought that efficiency and effectiveness in health care could be improved using the same tools used in other areas of business, and employers know that efficiency and effectiveness costs less. Employers need to find and reward providers and align incentives.

Whitney stated that the fundamentals of BTE are: 1) pay rewards after providers show high performance, 2) encourage employees to seek quality performers and create incentives for consumers, and 3) choose good performance measures.

BTE started in the Louisville and Cincinnati markets, and has expanded to Boston and Albany. There are 350,000 eligible lives in those four markets.

In Louisville, there is one group practice; everyone else is in small independent practices. It was difficult to implement the program in Louisville because the program depends on chart extraction. In Cincinnati, a third party went in and helped with chart extraction. In Boston, there are large group practices, so a train-the-trainers approach was used. In Albany, most IPAs welcomed the project.

BTE has engaged employees in several ways. He said BTE will be launching a physician report card sometime in 2005. There are also new incentives for employees to move to a BTE physician.

The BTE approach is being adopted by other entities, which serves as “proof of concept.” CMS is pursuing similar work, so the public and private sectors are in the same markets with the same measures. United Healthcare has a licensed BTE program. The National Business Coalition will introduce four sites in 2005, with more to follow later. In addition, there is interest in nearly 30 markets across the country.

BTE has begun to look at outcomes. Relative to other physicians, diabetes BTE physicians (recognized by the program) are more efficient by 15 percent when looking at diabetes costs alone and are 5 percent more efficient overall. This means savings of \$250 per patient in the first year.

Whitney stated that future steps may include a primary care physician recognition program, cancer care, etc. See www.bridgestoexcellence.org for more information.

Thomas Lee, Jr. Partners Health

The BTE design team uses a sixth sigma approach, looking at things that maximize value. Dr. Lee described it as a wonderful, rigorous process. BTE takes error reduction as the approach to quality improvement, including overuse, underuse, and misuse. It’s based on the notion of “delaying” which is very much a GE idea. It’s the idea of cutting out the middleman whose

function is to detect errors; that's inefficient error correction. Rather, BTE rewards physicians to get it right the first time.

According to Dr. Lee, the first rounds of BTE aren't perfect but you have to start somewhere. Consumerism and pay for performance will result in clinical reengineering and eventually "chasm crossing." BTE has a three-component strategy. First is pay for performance contracting, which puts 10 percent of payment at risk (based on performance). Second is to create products with transparency to consumer in terms of costs and quality. Third is the "build a Prius" initiative, meaning that you give the purchaser some hope that there's a better health system coming soon.

Dr. Lee stated that they really want pay for performance to work. They have 500,000 PCP lives and 500,000 specialty care lives involved. And there is \$5 million of incentives in play here. The alternatives to pay for performance are "ugly"; he doesn't want a swing back to capitation. BTE success requires two revolutions. One is the industrial revolution, which is the adoption of electronic and other tools. The second is the cultural revolution, in which physicians begin to understand that they are part of a team whose focus is caring for a population of patients over time.

Dr. Lee believes there are lessons from prospect theory that apply to pay for performance. There is more emotional impact from small losses. Multiple small packets of money are better than bottomless risk (as with capitation).

Under pay for performance, Dr. Lee believes there is more focus on effectiveness than under capitation. Providers initially greeted pay for performance with suspicion. Now BTE is making its way into contracts, which is encouraging.

Thomas Granatir, Humana

According to Granatir, pay for performance is a long-term pursuit. BTE may have an impact in three years. For example, BTE saw payback in Louisville and Cincinnati on diabetes in three years.

IOM's Report *Crossing the Quality Chasm* is the genesis for a lot of work on pay for performance, according to Granatir. The theory of pay for performance is really about reengineering systems and creating more "systemness" in the system. Louisville is focused on the micro decisions of physicians, whereas Albany has a *microsystem* focus. In Louisville and Cincinnati, BTE rewarded physicians are becoming diabetes recognized providers. In Albany and Boston, the program is more focused on systemness to achieve savings but less specific about the exact track to savings. In the long run, the only way to get sustainable change is to change systems.

Granatir stated that in the late 1990s through 2000-2001, plans were moving away from the "police state" of managed care and trying to find other ways. But plans still need to be accountable to their members and have to create more transparency.

BTE conducted focus groups in which physicians indicated they should not be accountable for patient noncompliance. So BTE has created incentives on the patient side.

As far as measures, BTE can do medical record review on the effectiveness side. However, there are no standards now for patient data and those have to be developed.

BTE has faced several challenges. As far as employer recruitment, BTE has been successful generally but has found it hard to recruit additional employers in Louisville and Cincinnati. According to Granatir, a lot of employers don't consider long term but instead are very short-sighted. Additionally, some employers take on less responsibility to try to change the market. Employers can only be market makers if they work together.

Physician recruitment is another challenge. A lot of practices don't have the necessary infrastructure. A few said that they didn't want to be identified as a best diabetes provider so they attract more (sick) patients. Finally, patient incentives are a challenge and it's not easy to get patients to "move"; however, there is a cultural shift occurring in this area.

Measures are another challenge. Programs need scientific measures that are easily understood by consumers. Plans generally are not enthusiastic about measures. Lack of member retention makes long-term incentives for plans difficult.

Granatir mentioned the Medicare CABG demonstration of the late 1980s and early 1990s. It saved Medicare \$50 million over 8 years. Granatir felt it was a big success and there should be other demos like it.

John Conklin, MedStat

Conklin offered his views on BTE from the perspective of program implementation. BTE rolled out 1.5 years ago in Louisville and Cincinnati, about 1 year ago in Boston, and 9 months ago in Albany. MedStat (which administers the program) has sent reward checks to 700 physicians.

Conklin noted that there are 89 pay for performance programs listed on the Leapfrog compendium. BTE is unique in that it's one of the few that are focused on the individual physician, not the medical group or IPA. Also, BTE is employer-based and the program design is based on the business case (excellent health care means healthier patients, which translates to cost savings for employers).

BTE includes outcome measures (not just process of care measures). Also, the size of incentives and rewards are based on and related to the level of cost savings generated. (Specifically, physicians get one-third to one-half of anticipated cost savings, and this represents new money, not taking away money.) Additionally, the program is focused only on those clinical areas where there is evidence. Finally, active consumer participation is a critical and unique aspect of BTE.

Because BTE measures lab results, blood pressure readings, and so forth, it requires medical record abstraction. Participating physicians' medical records are subject to audits and so far physicians have been pretty honest.

According to Conklin, the four challenges to BTE (and all pay for performance programs) are: 1) data retrieval and integration, 2) physician engagement, 3) consumer engagement, and 4)

estimating or quantifying return on investment (ROI). BTE has developed a ROI calculator that uses various assumptions in order to recruit employers.

Conklin stated that the three critical success factors are: 1) there needs to be a critical mass for clout (10 to 15 percent of covered lives in a population or market), 2) there must be active employer and health plan participation in the market, and 3) the program must be designed such that measures and rewards are acceptable to the physician community.

Question and Answer

Scanlon asked the audience whether pay for performance was hype or hope by a show of hands; most responded that there was hope.

When asked about examining quality by the race/ethnicity of patients, Whitney said BTE has not looked at race/ethnicity to date. Granatir noted that most plans don't collect race/ethnicity data.

In response to a question about adjusting for risk, Lee suggested that risk adjustment tools are pretty good but not perfect, and physicians worry a lot about risk adjustment.

A question was asked about why hospitals (which are often major employers) don't incentivize their employees. Dr. Lee responded that with the labor shortage, employees have the upper hand in terms of power. Conklin noted that one of the early BTE participants was Cincinnati Medical Center.

PRESCRIPTION DRUG DISCOUNT CARDS

Julie James, Health Policy Alternatives, Inc.

Julie James presented the results of a study she worked on for the Kaiser Family Foundation. The project was intended to assess the Medicare Prescription Drug Discount Card Program and Transitional Assistance Program, mainly from the beneficiary perspective. Some of the questions they hoped to answer were:

- Are discount cards providing good value?
- What is Medicare doing to promote the program and advise beneficiaries?
- How well are the cards coordinated with state pharmaceutical assistance programs and pharmaceutical manufacturer programs?

The discount card program was an interim program established by the Medicare Modernization Act to provide relief to seniors during the time the government was implementing the Medicare prescription drug benefit. The law was passed in December 2003, and by May 2004 cards were offered.

Medicare beneficiaries who signed up for a card could be charged an annual fee up to \$35. Beneficiaries who had income below 135 percent of the federal poverty level and had no prescription drug coverage were also eligible for an annual \$600 in transitional assistance.

In total, 72 national and regional cards were offered. There were 39 general national cards and 33 regional cards. The numbers do not include exclusive cards offered by Medicare Advantage organizations only to their members. About 53 percent of the card sponsors were pharmacy benefit managers, 13 percent were managed care organizations, and 28 percent were other entities that included discount card vendors, retail pharmacies, the chain drugstore alliance, third party administrators, and information technology firms. While there were 72 card sponsors, most of the card contracts were administered by a few pharmacy benefit managers/third party administrators. For instance, AdvancePCS administered 14 cards, Anthem Prescription Management administered 10 cards, and Express Scripts managed nine cards. Network and drug prices among the different cards administered by the same organization were very similar.

Medicare beneficiaries generally enrolled through the card sponsor. The card sponsor then had to get verification from CMS that the individual was eligible. Individuals enrolled in Medicaid were not eligible for the discount drug card program. Most applications could be processed over the phone. If an individual was signing up for the transitional assistance benefit, a signed application was required. CMS did allow for auto-enrollment of enrollees in Medicare Advantage plans that offered a card and enrollees in state pharmacy assistance programs. The agency also facilitated enrollment for Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries by mailing these individuals a letter telling them to call a number to activate the card.

Outreach for the prescription drug cards were done through the 1-800-MEDICARE telephone line, the www.medicare.gov Web site, grants to state and local beneficiary education organizations, and through ads and direct mail. Card sponsors also set up toll-free telephone lines, set up Internet sites, and had printed materials.

As part of the project, James analyzed the costs for prescription drugs for four prototype Medicare beneficiaries in two communities using six different discount cards and compared those costs to retail and mail order prices. They also examined the prices offered for the 10 most commonly prescribed medications to seniors. All six of the cards provided savings over retail prices, with greater savings available if the individual used mail order. When they examined mail order prices using the cards compared to prices available on Costco.com and drugstore.com, they found that all of the cards beat Costco.com prices and drugstore.com prices came in the middle.

James also said that the savings individuals received varied significantly by which discount card was used. The price difference between the card with the highest price and the card with the lowest price ranged from a \$45 difference per month to a \$142 difference per month among the four prototypical beneficiaries.

One of the concerns was that card sponsors would increase prices as the program went on since they were allowed to change their prices on a weekly basis. James said she found prices to be relatively stable.

In summary, some discount cards offered very good value compared to retail drug prices. Enrollees in the transitional assistance program got even more savings. Enrollees that used generic and mail order drugs saw even greater savings. Also, the choice of card mattered to individuals. There was no one discount card that always offered the best price.

James also summarized the lessons learned from the discount card program that could be transferred to the Medicare prescription drug benefit (Part D). First, while beneficiaries value choice, excessive choice can be too confusing and result in inaction. Most Medicare beneficiaries are not Internet users. Instead, Medicare beneficiaries prefer one-on-one counseling. The reliability of the drug card data on the Medicare.gov Web site was uneven, and could make beneficiaries upset when they went to the drug store and found different information. Finally, individual enrollment in the program has lagged.

Tim Trysla, Centers for Medicare & Medicaid Services

Tim Trysla provided an overview of how the discount card program has worked from CMS's perspective and the lessons they have learned from the program. He began by stating that CMS has now moved toward putting its effort into the Part D drug benefit. The discount card program was only intended to provide immediate relief to beneficiaries.

Many people were worried about constant change in formularies and drug prices. However, prices and formularies have remained stable in the program. Trysla also said that a lot has been made about how confusing the program was to beneficiaries. He noted CMS intended that the Web site be used primarily by beneficiary educators and CMS staff (including 1-800-MEDICARE help line staff). When individual beneficiaries called up the 1-800-MEDICARE line, they were only ever given five discount card choices at a time.

The prescription discount card program also provided CMS with the opportunity to work with new types of providers, such as pharmacy benefit managers and pharmacists. It also gave CMS the opportunity to start educating beneficiaries about generic versus brand-name drugs and how prescription drug programs work.

One thing CMS learned was that there is an atmosphere of cynicism about government programs, even among seniors. When CMS mailed letters to individuals in the Medicare Savings Program that only required the individual to call into a number to activate their card, there was still a very small uptake in enrollment. Some of this is because consumer advocacy groups have been so effective in teaching seniors to not open mail or not believe certain information they receive. Also, seniors like to use the phone to get information. Finally, the No. 1 concern for seniors was access to their local pharmacies.

Given the lessons learned, Trysla said CMS is better positioned for the 2006 benefit. CMS is doing auto-enrollment for dual-eligibles into prescription drug plans in 2006. While individuals will be automatically enrolled in a plan, they will also have the opportunity to change plans if they want to. The agency has also learned a lot about doing outreach over the phone and the need to work with local community-based organizations to get low-income seniors into the program. He noted that the CMS actuaries initially estimated that low-income seniors would enroll in the discount program at a rate three times greater than other seniors. Instead, they have found that middle class seniors have enrolled at a rate three times that of low-income seniors.

Given the experience with the discount card program, Trysla said that he doesn't anticipate that CMS will have problems attracting or working with business partners. Instead, the biggest challenge will be enrolling seniors into the program.

Vicki Gottlich, Center for Medicare Advocacy

The Center for Medicare Advocacy is an organization that works to increase access to comprehensive Medicare coverage and health care for elders and people with disabilities. The Center did not support the Medicare Modernization Act, but since it became law they have joined the Access to Benefits Coalition and conducted seminars to educate consumers about the law and the discount card program. They have also written information for consumers and advocates.

One of the projects the Center did was a 10-week study of prescription drug card costs. A summer intern at the Center looked at the prices of the 10 most popular drugs identified by the Pennsylvania State Pharmacy Assistance Program and Multiple Sclerosis drugs in three zip codes (D.C., rural Connecticut, and suburban Maryland). Over the 10 weeks, they did not find consistent increases in prices.

Gottlich identified five lessons from the discount program for 2006:

1. Simplify. Beneficiaries, families, and advocates complained that the program was too confusing because there were too many plans and too many factors to consider. As a result, many people didn't enroll even if they were eligible for the \$600 or if they could have saved money.
2. Need for accurate information. Information listed on the Medicare.gov Web site was sometimes inaccurate. For instance, some cards listed out-of-business pharmacies or pharmacies were listed as accepting a card when they didn't. Additionally, the prices on the Web site were sometimes different than the prices individuals found at the pharmacy. People got very upset at these glitches in the system.
3. Need for consistent information. Discounts varied by zip code and by pharmacy. Some drugs had greater discounts than others. The same card didn't always have the best prices.
4. Need for reliable sources of information. Gottlich mentioned that the Government Accountability Office gave the 1-800-MEDICARE line a failing grade for providing accurate information. Advocates and beneficiaries had little luck getting help from regional CMS offices. Health plans and pharmacies often gave out inaccurate information. Also, there was no place for individuals to go to file a complaint. Finally, Gottlich said State Health Insurance Assistance Programs (SHIPs) were overwhelmed.
5. The Internet isn't the way to go to get information out. Gottlich cited a Kaiser Family Foundation survey that found about one-third of seniors have gone online. The Center for Medicare Advocacy also did an informal survey of individuals aged 54 to 93 in August/September 2004 and found that only 13 percent had used the Internet. Many

individuals said they couldn't afford a computer or the monthly Internet fees, or they do not have printers.

Gottlich had five recommendations to CMS for 2006:

1. Simplify the choices since too many plans and too many variables lead to people making no choice. This will be particularly important in 2006 since people face financial penalties if they do not enroll right away.
2. CMS should provide as much information as possible to individuals in writing and in advance of them having to make a decision.
3. CMS should make sure the information is accurate since individuals are locked into their prescription drug plan for a year.
4. CMS should establish quality controls and test for accuracy on their 1-800-MEDICARE line.
5. CMS should provide additional funding for SHIPs.

SCHIP REVISITED: REAUTHORIZING THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Debbie Chang, Nemours Health and Prevention Services

Chang sketched the history and basic structure of SCHIP—its 1997 enactment with bipartisan support, 10-year block-grant funding, federal matching rates that exceed those for Medicaid, and the states' flexibility in setting eligibility thresholds and benefit design. While the states embraced SCHIP and the federal government cooperated in working with the states to facilitate development of the program, the time pressures associated with using available funding have produced "strains," she said. The program's flexibility has fostered innovation, although she noted that evidence about the impacts of program design choices is lacking and weaknesses in available data make it difficult to assess state-level effects.

Chang observed that SCHIP now covers millions of children, and it has improved insurance coverage among children. Moreover, enrolled children do have improved access to care. However, she noted, progress in enrolling children has stalled: national enrollment in SCHIP actually declined over the last half of 2003.

Chang identified inequities in funding, eligibility, and benefits as basic issues for the program. She noted that crowd out remains a concern, though there is little evidence that it has occurred. Coverage of adults in SCHIP exposes the tradeoff between benefits and enrollment with which the states are grappling—while federal funding of the program has led to uncertainty and projected shortfalls.

Genevieve Kenney, The Urban Institute

Kenney concurred that SCHIP is an important source of coverage and access to care for millions of children, corresponding to a reduction in the number of children who are uninsured—especially among children with household incomes between 100 and 200 percent of poverty, the population targeted by SCHIP expansions.

However, she said, the program has a number of important shortcomings that should be addressed in reauthorization. These include:

- The states were forced to develop and implement their programs in a very short timeframe to capture available federal funding. While the compressed timeframe made coverage available to children very quickly, it also affected how states designed their programs and frustrated the development of management information systems to track progress.
- Evidence is lacking to guide the choices that states may make about the program's relationship to Medicaid, eligibility and renewal practices, benefit design, and outreach. And without federal assistance, few states have the resources to develop credible estimates of SCHIP's impact on coverage within their own state.
- Layering SCHIP on top of existing programs created challenges for coordination and equity. Some families were required to go through two eligibility processes, for Medicaid and then for SCHIP. SCHIP's crowd-out provisions penalized children whose parents had been struggling to pay for coverage, often with only narrow or catastrophic benefit coverage.
- SCHIP offers more comprehensive coverage than many private plans to children whose parents otherwise could not afford it, but by a categorical (0-1) measure of coverage, it appears to crowd out private coverage for some enrollees. Conversely, some SCHIP-eligible children remain uninsured, and many states have reduced outreach.
- State budget pressures have forced cutbacks—including enrollment caps, reduced eligibility thresholds and outreach, and increased cost sharing—while federal funding practices have produced considerable uncertainty and potential shortfalls.
- SCHIP coverage of adults has introduced inequities and tradeoffs among states, and it is increasingly likely that coverage of adults—especially nonparents—will cause some states to have insufficient federal resources to cover children. Conversely, broadening SCHIP to cover low-income parents and nonparents may undermine the bipartisan consensus used to create the program.

Kenney concluded by noting some concerns for federal reauthorization. Additional policy changes may be needed to ensure coverage for all children, she said. Reliance on incremental expansions of coverage that are optional and require state funds may not succeed.

Additional investments—likely requiring a federal role—are needed to finance and support the development of data collection and research to better understand the effects of the states’ differing program features. State and national policymakers will need this information, she said, to address SCHIP’s issues related to program structure and financing.

Finally, SCHIP’s financing issues relate not only to the funding formula—causing shortfalls in some states, while others are returning unspent funds to the federal Treasury—but also to how the states have extended eligibility for SCHIP. It is likely that the way SCHIP is financed will limit what it can ultimately accomplish, she said, since the amount of federal resources block-granted to the program is not adequate to cover all children potentially eligible for coverage.

Margo Rosenbach, Mathematica Policy Research

Rosenbach described the evidence from state and national evaluations that could form a framework for change to the program in the process of congressional reauthorization. “A wealth of evidence,” she said, resides in federal evaluations of SCHIP, as well as in evaluation initiatives funded by foundations, federal/foundation partnerships, state evaluations, and other studies. These studies offer tangible evidence of progress in expanding coverage among children, especially among near-poor children (100-200 percent FPL) to whom SCHIP is targeted. Without SCHIP, she said, children’s coverage might have declined.

Moreover, many studies suggest that access to care has improved for children enrolled in SCHIP, Rosenbach said—especially for children who were uninsured prior to enrollment. The lack of consistent data and differences in program characteristics make it difficult to derive a single estimate of these effects. Nevertheless, in light of the secular decline in private insurance, national focus on reducing disparities, concerns about an epidemic of chronic disease, and broader awareness of children’s mental health needs, she asserted that “SCHIP is more important than ever.”

Rosenbach summarized a number of lessons from SCHIP that should be incorporated into an evidence-based framework for reauthorization. SCHIP’s flexibility—mixing Medicaid and private models, and allowing states to vary eligibility thresholds, benefits, delivery systems, and other features—created “opportunity,” she said. Eliminating choice of models and features would restrict state flexibility and “may reduce commitment to SCHIP.”

Rosenbach also pointed to seven states’ experience capping or freezing enrollment as instructive. Specifically, she said, waiting lists raised equity issues, as the programs’ focus shifted to “inreach” and renewing enrollees in the program. Subsequently opening enrollment revealed pent-up demand, she said.

Nevertheless, the “nonentitlement” nature of programs that were separate from Medicaid proved to be an asset in stimulating expansions in SCHIP eligibility and coverage, though important gaps in coverage remain. SCHIP excludes coverage of children who are in institutions for mental diseases, incarcerated, aged 19 to 21, undocumented, or whose parents are eligible for coverage under a state public employees’ plan. All of these, she said, limit progress toward universal coverage of children. In addition, she observed that some states’ use of SCHIP to cover not only parents but also childless adults raises equity concerns, when other states have insufficient funds to cover uninsured children.

Rosenbach also described the states' experience with "Medicaid spillover"—that is, the identification of children eligible for Medicaid in the course of SCHIP outreach. She noted that SCHIP's "screen and enroll" provision requires coordination between SCHIP and Medicaid, though lack of coordination at renewal remains an issue in some states. Nevertheless, experience in facilitating SCHIP enrollment had caused many states to streamline their Medicaid enrollment and renewal procedures as well. As a result, public coverage of children has returned to pre-welfare-reform levels, she said, although coverage of adults has not.

Rosenbach noted that many states had enhanced SCHIP's benchmark benefit package in order to meet children's health care needs—especially with respect to dental and vision care, and various therapies. In some states, benefits have fluctuated with available funding, marking the tension between covering more kids and covering more services. Nevertheless, she said, standardizing the SCHIP benefit package could make it harder to tailor the programs to local markets.

Rosenbach also said that there was little evidence that families had dropped private coverage to enroll their children in SCHIP—though some children who enrolled in SCHIP may have been eligible for private coverage. Congress might consider ways to make it easier for SCHIP to buy into employer coverage—using direct SCHIP coverage "as a last resort," she said. Title XXI created barriers to developing such premium assistance programs—including benefit comparability, minimum employer cost sharing, and evidence that a buy-in is cost-effective. The Health Insurance Flexibility and Accountability (HIFA) demonstration initiative eased restrictions on premium assistance programs, she said, and reauthorization could improve coordination with employer-sponsored insurance by incorporating HIFA's flexibility.

Both OMG and OIG have noted deficiencies in performance monitoring under SCHIP. And while states have made progress in reporting, Rosenbach said, many inconsistencies remain. The lack of individual-level data on enrollment and claims-level data on service use are important barriers to monitoring SCHIP performance. Reauthorization, she said, could strengthen performance monitoring by requiring submission of individual- and claim-level data—similar to that required by Medicaid.

Finally, Rosenbach pointed to a "common perspective" that the SCHIP allotment formula is flawed—in addition to the problems that arise from an inaccurate count of each state's low-income uninsured children, to which the formula is applied. Specifically, the formula does not account for progress in covering kids in SCHIP. Rosenbach urged that the reauthorization process invite expert help in assessing alternative formulas and their consequences.

Lesley Cummings, California Managed Risk Medical Insurance Board

Cummings spoke broadly about SCHIP and also about California's SCHIP program, Healthy Families. SCHIP administrators, she said, widely believe that the program is a success. In California, Healthy Families covers 700,000 children and has measurably improved access to care and health status among beneficiaries. She said that California and many other states have used the flexibility in program design and provisions that SCHIP offers, a process that has driven thinking about and changes to the Medicaid program. SCHIP's focus on coverage for children and working families has broad popular appeal, which in California has protected it from funding cuts despite the state's severe fiscal problems.

The Pew Charitable Trust has funded a multi-year study of health outcomes among SCHIP kids in California. This study concluded that, while children are generally quite healthy, those with the poorest health experienced dramatic, sustained improvement in health status while enrolled in Healthy Families. They also reported a lower incidence of foregone health care and improved ability to pay attention in class and keep up with school activities. These results were consistent across all children, regardless of race, ethnicity, or other factors.

Cummings said that what administrators want most from the coming reauthorization of SCHIP is, of course, continuation of the program and continued favorable federal matching. However, they also want even greater flexibility at the intersection of the program with Medicaid, and sufficient and reliable federal funding. She said that the overall amount of federal funds appropriated to SCHIP was adequate for a program in start-up mode, but the formula maldistributes funding among states. She noted that states that had underspent their federal funds in the past did so, not for lack of need, but because it took time to “ramp up” to meet need. States that overspent their federal funds had mature programs already in place, as well as a state commitment to such programs.

Reviewing the fiscal outlook for California’s Healthy Families program, Cummings noted that the program’s carryover federal funding will be exhausted by 2007, forcing the state’s effective matching rate to cover program expenditures to rise. While California forfeited \$1.5 billion in past years to other states that had overspent their federal allotment, federal rules offer no means for recouping those funds

Cummings observed that the states’ experience with SCHIP offers important lessons for the program’s federal reauthorization. First, she said, maintaining SCHIP will take higher appropriations than in past years. “The SCHIP dip won’t work again.”³ Second, because parental coverage substantially improves enrollment among children, “parents and children should be covered together.”

Cummings also observed that experience with SCHIP offers some lessons for the concept of block granting Medicaid—despite important differences between the populations that SCHIP and Medicaid serve. California’s share of Medicaid funding is “artificially low,” she said, reflecting the state’s low federal matching rate and “very cost effective” program. If SCHIP, the “golden child,” is under-funded going forward, Cummings wondered what implications might be drawn for how a federal Medicaid block grant might evolve.

³ The design of federal SCHIP funding included what is known as the “SCHIP dip.” To meet congressional budget limits, federal funding was designed to decline from \$4.3 billion in 2001 to \$3.1 billion in 2002, and then gradually increase to \$4.1 billion in 2005. The Administration estimated that once funds carried over from previous years were spent, enrollment in SCHIP would decline by about 900,000 children from its expected peak in 2003 (http://www.allhealth.org/sourcebook2002/ch2_4.html, accessed February 16, 2005).

Becky Shipp, Senate Committee on Finance (majority)

Shipp recalled that it was the scheduled reversion of SCHIP funds to the Treasury that first drew congressional attention to changing the program to allow the distribution of unspent funds to states that had outstripped their federal allocation. She noted that part of problem with this approach was that it failed to ensure adequate funding to any state as it enrolled more kids.

However, attention to the fiscal aspects of the program, Shipp said, “inevitably draws attention to its policy parameters”—in this case, raising questions about whether states’ inclusion of parents and children at higher incomes was consistent with the law’s initial concern about kids under 200 percent of the federal poverty level, as well as questions about how the program could better serve the Native American population. While the Finance Committee was unable to work out all issues before the Congress adjourned, she said, “they came to a much clearer understanding” of the number of states that will experience funding shortfalls in the next five years and the magnitude of the shortfalls. She observed that redistribution of expiring allotments will not cover the shortfalls, even in 2006.

For this legislative session, Shipp listed the Committee’s priorities as: 1) recapturing the \$1.1 billion in SCHIP funds that are expiring, 2) addressing shortfalls in the states’ funding where they occur, and 3) addressing the issue of parents’ coverage.

Question and Answer

Discussion following the presentations focused on the availability of information about the programs, which—consistent with the program’s flexibility—vary in important ways from state to state. Cummings commented that substantial information about these programs is available, despite a general perception that information is lacking. She also noted that, as states have needed and used flexibility that allows for creativity—creating both diversity and information challenges—“it should be supposed that some states will develop programs with features and results that others may disagree with.” Chang noted that many states believe that, without such choices, they could not have convinced the governor or legislature to go forward with the SCHIP programs.

Kenney noted that the implications of state choices are little-understood: there is little basis for understanding effective outreach, the implications of additional cost sharing, or the implications of state choices about benefit design. “Flexibility is key for state buy-in,” she said, “but we need to understand the implications for policy purposes.” Rosenbach noted that, while good cross-sectional studies have not been conducted, “there are a number of fairly good pre-post studies” conducted at the state level, including research on active recertification versus passive reenrollment, enrollment drop-off associated with recertification at 6 versus 12 months. “They don’t satisfy the demand for national-level evaluations,” she said, “but it is important to disseminate these state studies.” Still, Cummings warned that such studies may not “transfer to other states” that are considering changes that may differ in their specifics, and also in their context.

The session moderator, Alan Weil (National Academy for State Health Policy), asked the panel to comment on the prospects for SCHIP in this Congress. Shipp noted that there are significant issues with reauthorizing the program, and that the worsening fiscal circumstances are

likely to complicate a drawn-out controversy—especially over the formula for allocating funds. She urged states to offer thoughts on how these issues could be resolved.

Chang observed that debate about the funding formula “will swamp thinking about programmatic issues.” “Focusing on programmatic and design issues are critical,” she said. In response to further questioning, Chang noted that SCHIP’s “balancing act” between federal standards and state flexibility offers important lessons for the Medicaid program. For example, Medicaid’s eligibility structure—including some 48 categories of eligibility—is very complicated. In contrast, the simplicity of SCHIP eligibility has made it more accessible and understandable to enrollees. In addition, SCHIP may offer lessons about benefit structure, enabling the program to accommodate lower-income enrollees who need a full benefit package, as well as higher-income enrollees who might need less coverage. Finally, Chang noted that federal funding for SCHIP is complicated. The complexity of that financing should be resolved, she said, before considering changes to Medicaid financing. Shipp added that the Medicaid program has 40 years of experience, versus about 10 years for SCHIP, and “what may work as a solution for moms and kids may not work for the elderly, disabled, and other optional populations.”

Cummings concluded the session, noting that there was reason for caution in drawing inferences from the states’ experiences with either SCHIP or Medicaid to support change to the other. She observed that SHIP has “not been tested yet.” Favorable federal matching and adequate aggregate funding have provided the system with “plenty of money,” she said, in contrast to the history of Medicaid.

HEALTH POLICY IN 2005: COVERING THE REAL CRISES

Susan Dentzer, “The NewsHour with Jim Lehrer”

Dentzer first summarized a story she had seen recently in *The Washington Post* that illustrates how the media uses stories to bring the public information about real issues. The story was about a 53-year-old self-employed carpenter who needed heart valve replacement surgery. The man went to his local hospital to see how much the surgery would cost and they quoted him a price of \$50,000 - \$200,000. Instead of getting the surgery at his local hospital, he explored getting the surgery in India. He wound up getting the heart valve replacement surgery in a hospital in India that was founded by an Indian doctor trained in the United States. The total cost of the treatment was \$10,000, including flights to and from India.

Dentzer said that the story came during an election season where health care didn’t get much attention. As a follow-up to the article, Dentzer wrote an op-ed piece for *The Washington Post* that said that the solution to our health care crisis was to outsource all care for the uninsured to India. Based on the savings the carpenter got, she estimated we could care for all of our uninsured for \$10 billion per year. The op-ed piece attracted a lot of attention, including people who wanted information on the hospital in India so they might get care there. An Indian man also proposed a business partnership.

Dentzer went on to say that the real crisis in American health care is not just the 45 million individuals without insurance, or the cost of care, or the unaffordability of coverage to

employers, it's all of that together. She stated that America pays the highest prices in the world for health care and we have no confidence we're getting high quality of care.

Dentzer noted that she has been covering the health care crisis for two decades. The only difference over time is that the crisis is facing so many more people, and much more money is at stake.

Health services research, she said, is necessary for the media to understand what these individual stories mean, whether they are just anomalies or are indicative of a wider phenomenon. She said that she assumes that health services researchers have a vocational calling to improve the health care system. In order to do that, health services researchers need to produce data and research that is relevant, digestible, and understandable.

For instance, Dentzer asked whether we really know what the additional costs of the uninsured are on our system or how many lives it costs. She stated that the Institute of Medicine estimated that uninsurance leads to 18,000 additional deaths a year. She stated that 18,000 is less than the number of individuals who die each year from leukemia, which is not one of the leading cancers. She wants to know whether we are counting the numbers right, and if we are, why are the numbers so low? Is it because getting half of the care we think we need is not as bad as we may think? If uninsurance is a bad thing, Dentzer said we need to keep the issue in the forefront.

Most people understand that new technology is cost enhancing in health care, rather than cost saving like in other sectors. She wondered whether there are any technologies that are cost reducing. And if not, then will they never be cost reducing, or just not yet?

Another issue is how the consumer-directed health plans trend will play out. She wondered whether it would be like managed care in that it would see early gains, then everybody will be in the plans, then some problems will be identified, then there will be a huge backlash.

In terms of health care prices, Dentzer said one area she was interested in was how much the high health care prices in the United States are related to commodity pricing. Are the high U.S. prices a result of the United States being the largest capitalist system in the world?

The Medicare Modernization Act presents another set of questions, according to Dentzer. What is the effect of the MMA on drug prices? What are the actual prices that pharmaceutical companies will be paid? Will prices be consistent? Will prescription drug coverage spark new trends in utilization? Will there be cost offsets from the drug coverage in other care settings? And, how many Medicare beneficiaries will understand the benefit?

Dentzer stated she understands that health care is really a series of local markets and clearly there is wide variation among local communities that are driven by, among other things, the supply of physicians. Dentzer wanted to know whether a global health market will evolve, and if so, will it drive down prices.

All of these issues are ones that health services research can play a role in by providing meaningful data, according to Dentzer.

Question and Answer

Dentzer was asked what the media could do to get the issue of the uninsured back on the policy agenda. Dentzer responded that the media will always be able to run stories about individuals. However, she noted that it is helpful to have the data and research to hang those stories on. She said that the media needs to be able to continually point to newer research and data.

Another audience member asked why there is no attention at the White House level to Medicaid and how can the media help get the story higher up on the agenda. Dentzer noted that Medicaid is a hard story to cover in the media because it takes so much explanation to set up the story and inform viewers about what Medicaid is. For instance, when she does a story on Medicaid she has to explain that it was a program for the poor, but now it is also a major provider of coverage for the disabled and elderly. Those kind of explanations make it hard for the media to do stories about Medicaid when they only have a limited amount of time. Dentzer did say she would be doing a story on TennCare shortly. She said that the plan at the NewsHour with Medicaid has been to bite the issue off story-by-story and hope that you can achieve greater understanding over the long term.

PRESIDENTIAL ELECTION OF 2004: IMPLICATIONS FOR HEALTH POLICY

Karlyn Bowman, American Enterprise Institute

Bowman noted that she doesn't think that polls should be used to make policy because they are too crude an instrument. However, there are now 12 national polls in the field on a regular basis and they can tell us things. She said that in general the polls show contentiousness and uncertainty.

According to Bowman, perhaps the most important poll numbers that were released came in early 2004. Gallup collected all of their responses to the question, "In politics today, do you consider yourself a Democrat, Republican, Independent, or what?" from all of its surveys in 2003. Altogether, Gallup had 40,000 responses to the question. They found that in 2003, 45.5 percent of people considered themselves Republican, and 45.2 percent called themselves a Democrat. Bowman said it was a rare moment of partisan parity. In no period in the 70 years of public polling was the public so closely divided. Gallup recently released the results of the same question for the year 2004 and found that 48 percent considered themselves a Democrat, and 45 percent a Republican. She noted that the public was still very closely divided.

Bowman went on to put these numbers in context. The Harris Organization looked at their answers to the same question in the 1970s, 1980s, 1990s, and today. In the 1970s, Democrats had a 22 percent advantage, in the 1980s they had an 11 percent advantage, and in the 1990s they had an 8 percent advantage. Bowman then discussed four reasons she believes are reasons the electorate is now so closely divided.

First, Bowman said there has been a generational change in the electorate. Individuals who came out of the Depression were wedded to the Democratic Party and they carried that party affiliation with them as they aged. She noted that the most Democratic leaning age group is individuals over 75. Now, those individuals are beginning to pass on.

Second, Bowman said that for many years all of the political icons were Democrats. She noted names like John Kennedy and Franklin Roosevelt. Now, we are seeing many more Republican political icons, such as Ronald Reagan, Rudolph Giuliani, and John McCain.

The third reason for the shift is there has been significant change within the Republican Party itself. George W. Bush was the first Republican candidate who could be called a Baby Boomer.

Finally, Bowman talked about George W. Bush's accommodation with Washington. In the 1940s and 1950s, Americans equated government action with progress. Bowman said that began to change in the 1960s. By the time of the Reagan years, Americans viewed government as a problem causer rather than a problem solver. Bowman said that Bush has brought a more nuanced view of government. This view is characterized by the realization that Americans want their government to do lots of things, but they still think it is wasteful and inefficient. Bush brought in his idea of compassionate conservatism. He has come to accept that the federal government has a large role, for instance in education with No Child Left Behind and with the Medicare prescription drug benefit.

Bowman said that these four reasons have led to partisan parity. She believes that elections will be very competitive in 2008 and 2012, but she thinks that for demographic reasons, Democrats will have the advantage after that. Given the closely divided country, it's unlikely that some of the events that used to cause big bumps in polls will have much of an impact. For instance, she expected that Bush's poll numbers before and after the State of the Union would be about the same.

From the exit polls, health care was not cited as a primary issue among many Americans. In an Associated Press poll, only 8 percent of voters said health care was the most important issue to them. Health care came in significantly behind Iraq, moral values, and the economy. Kerry voters were somewhat more likely to cite health care as a major issue. Still, Bowman does not believe that these poll numbers mean Americans don't care about health care. Instead, they mean that Americans care about a lot of different things.

Most Americans with health insurance are satisfied with the care they receive. Americans do say that they are concerned about the uninsured, but they prefer private-sector solutions to public ones. She noted that during all of the corporate scandals, Americans wanted the corporate executives punished, but in general they did not want a new federal agency created to deal with the problem. Bowman stated that Gallup has asked this question since the 1950s: "What do you think poses threat to the country, big business, big government or big labor?" Most Americans thought big government posed the biggest threat.

Bowman concluded noting that she does not believe the uninsured have dropped off the public's agenda. However, she said that if we rely too much on public polls about health care issues and not judge them within the context of larger issues, we would be misled not just in public policy in general, but in health care overall.

Thomas Mann, Brookings Institution

Mann started by saying that one of the questions that Karlyn Bowman's presentation brought to mind was "what is the connection between public opinion and public policy?" Also, to what extent do public preferences drive the policy agenda and how do those preferences get translated into policy? He noted that in the past two decades, the argument could be made that American politics and policy are driven by policymakers trying to shape public opinion and then use that opinion to buttress their existing views. He cautioned that it is a dangerous exercise because it tends to reinforce existing ideologies.

For instance, Mann noted that Bush is traveling the country to sell his ideas on Social Security. The trip is part of a broader attempt to change the public frame on Social Security. Mann said it will be interesting to see how this plays out and if it has any effect on public opinion.

The previous night was the State of the Union address. Mann shared some of his thoughts about the speech. First, Mann said that Bush is consistent. One of Bush's favorite sayings is "I mean what I say," according to Mann, and that seems to be one of his fundamental pillars. Mann noted that nothing in the speech came as a surprise.

Second, Mann said that Bush is "one confident man" not given to self-doubt. Mann stated that some may call this confidence arrogance, but he believes the confidence has served Bush well in his election campaigns.

Another one of Mann's impressions was that Bush is ambitious. Mann said that it has been striking from the beginning that Bush aspires to leave a mark on the presidency. Bush and Karl Rove obviously have big plans for the policy agenda and a lot of political aspiration for their party. Their game plan seems to be that if you confront obstacles, you just aim higher. Bush is willing to take risk, not just for himself but also for his country.

Mann also said he saw in Bush a political toughness that had not been seen early in his presidency. Bush presents a willingness to play hardball and do what it takes to win. That is why, according to Mann, people should be careful about declaring his Social Security plan dead on arrival.

Finally, Mann said that Bush is a man whose broad ideology trumps policy analysis. He said, however, that ideology doesn't necessarily trump political feasibility. Bush tries to succeed on his moral objectives and he doesn't get bothered by "pesky facts." Still, Bush is very willing to jump on any good news.

Mann said all of these traits serve Bush well to people who may be on the political fence. It gives the impression that the Republican Party is the party of strength. Mann said the risk of that strength is that he will pursue policies that don't add up and will come back to haunt us in the long term.

Mann stated that the Social Security debate will be a real test of our political system. He wondered whether we have the capacity to really debate the issues and ask critical questions. Mann said it will be interesting to see whether anything comes of this debate. And if something

does come, whether it will represent a profound philosophical shift from social insurance to an ownership society. More importantly, Mann wonders whether the public will understand what that shift means.

Mann went on to say that Bush believes he has a strong tailwind from his re-election, but really it was the smallest victory ever for an incumbent since World War I. Mann said that what the re-election really represented was a vote for stability. He said that the fact that people have sorted themselves out politically and ideologically will make it harder for Congress to deliberate and make sound public policy.

Mann then said that one of Bush's challenges is dealing with the timeline of a second term. He noted that traditionally the incumbent party loses seats in the mid-term election. Also, some Republicans may feel that the president can actually do them more harm than good. Finally, Bush must live with the consequences of his first-term decisions, including the tax breaks and Iraq. Mann noted that the nature of Bush's second term will be different than his first term. The first term was mainly a positive sum game. In the second term, we will be moving to a zero sum game where there will be winners and losers. Bush, Mann said, got his wish to be re-elected, but he now must face all of the possibilities and dangers that come with re-election.

Mann then discussed where health care fits into the agenda. Mann said that Bush only mentioned health care cursorily during his State of the Union, but when he did, it got a roar from Congress. Mann said Bush seems to have decided that he will stick with his piecemeal agenda that includes association health plans, tax credits, and malpractice reform. Mann added that such an agenda only patrols at the margins of the problems of cost, quality, and coverage.

Mann noted that Bush's long-term vision for the country seems to be built around the idea of an ownership society. In such a society, there would be more of an emphasis placed on individual reliance, and less of the government and community playing a role in social insurance.

Mann concluded by saying that wherever we go, he hopes we go with our eyes wide open.