

Controlling the Rising Costs of Health Care:

A summary of remarks
and recommendations
from an open,
non-partisan forum

Tuesday, March 13, 2007 • Marlborough, Massachusetts



MASSACHUSETTS HEALTH COUNCIL, INC.

The Massachusetts Health Council

The Massachusetts Health Council is a nonprofit, nonpartisan, statewide organization of more than 150 governmental and voluntary agencies, consumer and advocacy groups, professional societies and private corporations committed to improving and protecting the health of the citizens of the Commonwealth. The Council is a forum for health care leaders, who are often on opposite sides of health care policy issues, to come together to make a difference in improving health.

The mission of the Massachusetts Health Council is to:

- Inform and educate members and the general public
- Foster communication and cooperation among the health care community
- Sponsor forums for the debate of public health issues
- Review and take positions on proposals that safeguard health and promote wellness
- Provide a clearinghouse for ideas that generate opportunities and enthusiasm for feasible solutions to the common goals of improved health for the state's populations.

Since the inception of the Council 87 years ago, it has helped shape public policy in fulfillment of its mission. For more information about the Council, please visit our web site at www.mahealthcouncil.org.

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- 8:15 A.M. – 8:30 A.M. **Welcome**
Ralph Fuccillo
President, Massachusetts Health Council, Inc.
President, Oral Health Foundation
- Marylou Buyse, MD**
Vice President, Massachusetts Health Council, Inc
President, MA Association of Health Plans
- 8:30 A.M. – 9:00 A.M. **Opening Remarks**
JudyAnn Bigby, MD
Secretary, Executive Office of Health and Human Services
Commonwealth of Massachusetts
- 9:00 A.M. – 9:45 A.M. **Keynote Address**
Kenneth Thorpe, PhD
Robert W. Woodruff Professor and Chair of the Department of Health Policy & Management,
Rollins School of Public Health of Emory University
Former Deputy Assistant Secretary for Health Policy, U.S. Department of Health and Human Services

“The Rise In Health Care Spending And What To Do About It”

PANEL ONE DISCUSSION: HOW DID WE GET HERE – NO END IN SIGHT?

- MODERATOR:** **James W. Hunt, Jr.**
President and CEO, MA League of Community Health Centers
- PANEL:** **Brian Rosman**
Research Director, Health Care for All
- Kenneth Peelle, MD**
President, MA Medical Society
- Scott Plumb**
Sr. Vice President, MA Extended Care Federation
- Robert Gibbons**
Interim President and CEO, MA Hospital Association
- Julie Corcoran**
Deputy Vice President for Policy, Pharmaceutical Research & Manufacturers Association
- Adam Stavisky**
Senior Vice President, Health and Welfare Consulting, Fidelity Investments

PANEL TWO DISCUSSION: WHAT CAN WE DO ABOUT IT?

- MODERATOR:** **Lori Burgiel**
Executive Director, Health Care Administrative Solutions, Inc.
- PANEL:** **Meredith Rosenthal, PhD**
Health Economist, Harvard School of Public Health
- James Roosevelt, Jr., JD**
President and CEO, Tufts Health Plan
- Richard Lord**
President and CEO, Associated Industries of Massachusetts
- Senator Richard Moore**
Chairman, Health Care Financing Committee, Massachusetts State Legislature
- James Bryant**
Associate Regional Administrator, CMS Region I
- 11:30 A.M. – 12:15 P.M. **Summary of Suggestions and Solutions**
Kathleen O’Loughlin
President and CEO, Delta Dental of Massachusetts
- 12:15 PM – 12:30 P.M. **Closing Remarks**
Bertram Yaffe, President
The Erna Yaffe Foundation

Introduction

On Tuesday morning, March 13, 2007, Ralph Fuccillo, President of the Massachusetts Health Council, welcomed more than 400 prominent and influential stakeholders to an open discussion on the rising cost of health care. The group included representatives from the business community, state and federal government, trade associations, consumer groups, insurers, providers, and public policy advocates from prestigious academic institutions. The purpose of this open, non-partisan forum, Fuccillo said, was to “share ideas, if not always agree” and to take steps in working through what all acknowledged were highly complex, interrelated social, economic, and political issues.

Opening Remarks

JudyAnn Bigby, MD — Secretary, Executive Office of Health and Human Services, Commonwealth of Massachusetts

In comparing state budgets, Massachusetts carries “the dubious distinction” of having the highest per capita health care expenditures in the nation. Between 2000 and 2004, health expenditures by the Commonwealth grew over 8% annually, or about \$3.2 billion per year. Since 2000, the disparity between Massachusetts and the rest of the nation has widened, both in per capita dollars and rate of increase. These costs have reached critical mass; the trends are unsustainable. “The debate about affordability reminds us that unless we can control and even reduce health care costs, it is unlikely that everyone will have affordable health care in Massachusetts in the long-term. . . . If we knew how to control health care costs, we wouldn’t be here today.”

As part of Chapter 58 (the Massachusetts Health Care Reform Act of 2006), the legislature in its wisdom created the Health Care Quality and Cost Council. The Council is charged with creating and coordinating implementation of health care quality improvement goals while lowering or containing the growth in health care costs. Its mandate also includes improving quality of care and reducing racial and ethnic disparities in health. Helping consumers make better-informed choices (“consumer-driven health care”) is an important strategy. It assumes that when consumers are at risk for out-of-pocket expenditures

and are empowered with knowledge about benefits, risks, and relative costs to support health care decision-making, they will be incentivized to make cost-conscious decisions and will, ultimately, drive down the overall cost of health benefits.

Other state-endorsed strategies include better management of chronic disease, especially for those segments of the population who consume a disproportionately high proportion of total health care expenditures, and reduction of duplication and inefficiencies in government reporting systems. Also seen as very important is the encouraging of people to engage in healthier lifestyles, which will, presumably, save considerable money in disease management but will, predictably, take a long time for results to be visible.

Keynote Address

“The Rise in Health Care Spending and What to Do About It!”

Kenneth E. Thorpe, PhD — Robert W. Woodruff Professor and Chair, Department of Health Policy and Management, Rollins School of Public Health, Emory University

“Follow the money!”

The money trail reveals that over the past 15 years significant changes in clinical characteristics of patients have led to dramatic shifts in the distribution of health care spending. Data for Massachusetts are consistent with this overall picture. In the Commonwealth, about 75% of total health care spending is linked to chronically ill (often, multiply so) patients. The chronically ill receive approximately 56% of all clinically recommended medical care. The rise in prevalence of treated disease (e.g., diabetes, hypertension, hyperlipidemia, etc.) accounts for about two-thirds of the growth in health care spending, and “the rise in obesity prevalence (which doubled) has accounted for nearly 30% of the growth in health spending over the past 20 years.” These data “indicate a clear need for restructuring how we deliver and pay for health care services in Massachusetts.”

While patient characteristics have changed, the payment delivery system has not. It’s still stuck in a 1965 model that was focused on hospitals as the delivery sites, not designed to address patients with

multiple chronic illnesses, but rather patients with acute illness. Today there are 200,000 fewer hospital beds than 15 years ago. There has been a shift by hospitals in the allocation of resources into ambulatory care and drug treatment to treat the types of patients coming through the system today.

Rather than consider the changes in clinical characteristics of patients, most discussion of health care spending has focused on benefit design and health insurance or co-pay deductibles. However, health care reform must emphasize two major areas: delivery and quality of care. A systemic component must address how care is delivered and paid for in the US, including how to make it affordable for the insured (which makes up 85% of the population). Secondly, reform must improve the quality of care delivered to people and address gaps in care for all patients by integrating the uninsured into the system.

Hospitals are becoming proportionately less important, due to the increase in the numbers of patients who are chronically, not acutely, ill. In 1987, hospitals accounted for 45% of total spending; in 2003, 36%. Over the same period, prescription drugs and ambulatory spending increased from 5% to 12.3% of total spending. “Yet the way we pay for and deliver health care to patients in the 21st has not changed. [It is] still based on a 1965 model”... a fee for service system, Medicare being the “worst offender.”

Prescription drugs dominate the current expenditure profile for treatment of key chronic conditions versus in-hospital care.

	<i>In-hospital care</i>	<i>Prescription drugs</i>
Diabetes	19%	44%
Mental disorders	17%	40%
Hypertension	14%	54%
Hyperlipidemia	3%	72%

These and other data strongly suggest that prevention-based primary care (especially for the chronically ill) must be “the centerpiece of the delivery model. . . . This is where the money goes.” We need to provide care in an integrated delivery model but the challenge is that the model doesn’t exist. We have a fragmented, unconnected, independent delivery approach by no one’s fault. Reform needs to

consider what best practice is and come up with delivery innovations to better support the chronically ill and to put emphasis on prevention.

How to make health care more affordable? By building “a modern delivery system designed to provide cost-effective care to chronically ill patients.” In turn, this will require: (a) a modern IT (Information Technology) infrastructure; (b) new approaches for paying primary care physicians; and (c) financial approaches and tools (i.e., economic incentives) for engaging consumers in their own health care in order to increase patient compliance, which itself is “a major issue.” Other affordability issues include introducing a single claim form, developing a blueprint of health parameters to ensure minimum standards of quality, instituting an automated patient reporting system to reduce errors, and moving toward universal coverage.

Changes will not happen by themselves but rather evolve as we revise the way health care is paid for, putting emphasis on best practices for health promotion and prevention in order to change the characteristics that are driving the chronically ill. As a possible model for change, Catamount Health, Vermont’s state-funded insurance program for the uninsured that focuses on managing chronic illnesses, was described and discussed.

Panel One Discussion

“How Did We Get Here – No End in Sight?”

Moderator:

James W. Hunt, Jr. — President and CEO, MA League of Community Health Centers

In Massachusetts, we are talking about transitioning the health care system where every man, woman and child that is eligible will have health insurance benefits and will have access to care. Our panel this morning will address ways to control costs and care management in this health care transition economy. Hopefully, this panel will not only stimulate your discussion, but, in fact, inform it. At the end you will have the opportunity to ask questions to these sector leaders regarding the effect rising costs have on their sector.

Brian Rosman — Research Director, Health Care for All

Health care represents about 37 percent of the state budget, so every increase of 10 percent in health care costs translates to a 3 to 4 percent increase in the overall budget, which is unsustainable. Mr. Rosman agrees with Dr. Thorpe that health care reform will not work unless we do something serious about health care costs. Echoing Dr. Thorpe’s comments, the focus must be on chronic care and the payment system. The problem is the disconnect between what the system pays for and what patients really need. Rosman focused on a couple of recommendations that are proposed in a legislative agenda filed by Senator Montigny and Representative Marzilli to deal with the cost issues. The legislation proposes an agenda that focuses on “a really robust chronic care self-management program” with extensive state resources behind it. In doing so, the state must offer incentives to providers to improve care coordination. Mr. Rosman recommends a single payment for a year-long course of care, so providers have the resources they need up front, rather than, as currently, payment for episode-by-episode. One example of care coordination that works very well is the state SCO program (Senior Care Organization) whereby a single payment from both Medicare and Medicaid is put together to provide comprehensive integrated support for seniors. The legislation proposes expanding the SCO program for dual-eligible

disabled people as well as seniors. Also, he addressed the issue of cost sharing and co-payments. The proposed legislation recommends no co-insurance or cost sharing charge for chronic disease care and preventive care, but rather utilizing positive incentives. In closing, Mr. Rosman touched on the decrease in state funding for prevention programs over the last six years, as in The Tobacco Control program; inquiring where the payers have been on promoting wellness and integrating primary care and chronic care on self-management. Lastly, Rosman touched on the largely ignored sector of dental health care, noting that our Medicaid program has a dysfunctional dental system and the Commonwealth Care program does not include dental coverage for people above the poverty level. Stating that it's time for a much more aggressive intervention in dental care, Mr. Rosman feels that such a program would benefit the overall health of our residents.

Kenneth Peelle, MD — President, MA Medical Society

Physicians are not happy either with the current cost of medical care. However, it's important to understand that "we are victims of our own success." Since 1900 life expectancy in the US has doubled from about 40 years old to 80 years old. While this is positive, the rise in population is one of the factors straining our health care system. In looking at how we got here, Dr. Peelle identified four major trends that have changed health care over the last century.

- The first is in the area of therapeutics, or how we take care of patients. Today drugs play a larger role in health care, both prescription and non-prescription drugs. We've moved from the discovery of penicillin in 1928 to chemotherapy to the new wonder drug, Avastatin, which costs \$8000 a month. Likewise, in surgery we've progressed from exploratory surgery to minimally-invasive and replacement surgery
- The second major trend, diagnostics and the diagnosis of diseases, relates to the rise in diagnostic imaging. Looking back just 35 years, there were no CAT scanners, no MRI scanners and ultrasound was very primitive. Now with the current diagnostic imaging tools and laboratory testing, which have improved the rate and accuracy of diagnosing a patient's condition.

- The third trend is the arrival of widespread (though not universal) health insurance coverage. World War II saw the initiation of health insurance which was originally conceived as a catastrophic insurance. The payers of health insurance have changed from individuals to mostly employer-based payment and the coverage has moved from catastrophic to first dollar coverage and is still evolving.
- The fourth trend, the reimbursement system, is noteworthy because it has remained largely unchanged. Our reimbursement system, is based on common procedural terminology codes, (CPT codes), that were developed by the American Medical Association. This method works quite well for providers who do procedures like CAT scans or surgeries, but not for cognitive specialists. The problem is that whenever there is a movement to cut the cost of health care by decreasing physician fees, the response by physicians has been to increase volume. That's easier for a proceduralist to do than a primary care doctor, thus their payments have fallen behind other specialists.

While those are the trends that got us where we are currently, there is some argument over what we can do about it. More information technology to do cost-benefit analysis is needed because we have to understand more about the care that we're giving, what is worthwhile and what is not. The FDA must move beyond just approving drugs based on safety and efficacy, but also consider their cost benefit. Likewise, although doctors have long been advocates for their patients, they must realize that sometimes what's best for a particular patient may not be best for society as a whole. The increasing age of the population and the constant advancement of medical technology will continue to put pressure on the costs of medical care and force a discussion about how to say no to unlimited care in a rational fashion.

There is agreement that prevention (emphasizing personal responsibility) should be a major focus to slow the rise of health care costs. Approximately 35% of the deaths in the US right now are related to lifestyle habits, i.e. smoking, overeating and lack of exercise. The challenge, as Dr. Peelle sees it, is how do we realign the reimbursement system that we have now to focus on prevention?

Scott Plumb — Senior Vice President, MA Extended Care Federation

The long-term care perspective regarding health care costs is somewhat different than the general health care arena, primarily due to the nature of the type of care involved as well as the dependence on public payers. In trying to make some sense out of this system, Mr. Plumb addressed five points.

- First, long-term care is subject to very different inflationary forces than an acute or primary care system. Seventy-one cents of every dollar spent by nursing facilities is devoted to wages and benefits to the direct care staff. The care given is very hands on, not driven by technology, physical plant, equipment or research and development.
- Secondly, because of this difference, cost increases in long-term care have only been slightly higher than inflation in general and far less than cost increases in acute and primary care. After adjusting for acuity, nursing facility costs have increased an average of 4.9% per year from 1997-2004.
- Third, the nursing homes, unlike other home care providers, are almost exclusively dependent on public payers. Close to nine in ten have their care paid for by Medicare or Medicaid. Facilities have little or no ability to cross subsidize losses from inadequate public payers. Since Medicaid rates are about \$40 a day below cost, the cost to private care in nursing homes is driven up. While many payers believe that nursing home costs are very expensive, patients receive a lot of care for their dollar. For an average cost of \$210 a day, a nursing facility resident receives 3.6 hours a day of direct nursing care, 24 hours a day of nursing supervision, rehab services, social services, recreation, transportation, meals, room and board and much more.
- Fourth, cost containment strategies in long-term care have to focus on the place where care is provided. Payers must use the entire continuum of care to make sure people get the four 'rights' – the right care, and the right place, at the right time, for the right cost. Just as home and community-based care can be alternatives for certain

patients, so nursing facility care has to be seen as an alternative to more expensive institutional care in acute hospitals, inpatient rehab centers and chronic hospitals.

Mr. Plumb believes we have several major challenges as we look toward improving the health care system. Medicaid rates are grossly inadequate in covering the true daily cost of highly labor-intensive nursing home care. The challenge is to develop more home- and community-based capacity, so people who can be cared for safely and effectively at home remain there. Nursing homes must expand their capabilities as providers of subacute care and other specialty services, they being less expensive alternatives to extended patient stays in acute hospitals. According to Plumb, institutional long-term care is at a crossroads: “We must get it right very quickly, or aging baby-boomers are going to overwhelm the care-giving system.”

Robert Gibbons — Interim President and CEO, MA Hospital Association

Today I’m here representing the community of Massachusetts hospitals and we’re concerned about health care costs on several fronts. First, hospitals, collectively, are one of the largest employers in Massachusetts with 170,000 employees. Approximately 67 or 68% of the health care dollar inside the hospital world is spent on salaries and benefits. Secondly, we’re concerned because rising health care costs contribute to the underinsured and uninsured population, which has a reverberating effect on the financial state of hospitals, due to the cost shifting that occurs. I think we have a lot of good ideas on what to do about the health care crisis, but what is lacking is consensus on which issue to tackle.

Health care reform was passed in 2006, Chapter 58, which provides us the opportunity to work collaboratively to implement it. It’s important to note, however, that successful implementation of Chapter 58 might require some investment in order to save costs. Information technology is one area we need to make investments in the short-term to achieve long-term savings. Massachusetts hospitals embrace the concept of transparency but it’s not an end to itself. It should be meaningful, valid and fair to both patients and providers. Transparency needs to apply to all stakeholders in the system, not just

providers. It needs to encompass the concept of mutual accountability so that government and insurers are as transparent as providers in this paradigm change towards transparency.

A proper balance must be struck between regulation and the competitive marketplace. In the 1990's managed care was more about managing costs than it was about managing care. It didn't necessarily reform the system, in fact there was rebellion. Chapter 58 may go a long way towards looking at that balance and the Quality and Cost Council is a good place to start.

Massachusetts hospitals are doing a lot to effect cost management but we recognize we have to do more. It will take collaboration among all stakeholders including proper incentives in order to achieve this. As Dr. Thorpe stated, cost management involves working on preventive care with a real focus on chronic disease management. Improved information systems and information exchange must include communication across provider networks and the payer community. Another issue that needs to be addressed is the shortage of health care workers. Unless we get the supply issue under control, we will never get the cost issue under control.

Lastly, administrative simplification would improve efficiency but it cannot be done alone. It has been stated that for every hour of care giving that takes place in a hospital, there is one hour of paperwork. Common claims processing and common codes is one issue that we can readily achieve with collaboration. Currently hospitals are required to file on three separate forms the exact same data to the Secretary of Administration and Finance, the Division of Health Care Finance and Policy and to the Attorney General. It takes the equivalent of one and a half full-time employees to complete those forms. Another area that causes administrative congestion in health care is medical recordkeeping. Massachusetts has a law on the books that requires us to keep medical records for 30 years, while the national average is 12 years. Legislation filed by Senator Richard Moore, would move Massachusetts into the mainstream with 15 years.

I believe if all stakeholders work together on some of these smaller administrative issues, we would begin to see cost savings that would lead to more collaboration in addressing the larger issues.

Julie Corcoran — Deputy Vice President for Policy, Pharmaceutical Research & Manufacturers Association

A great deal of the effort to control costs has been aimed at cutting or reducing reimbursement, price controls, and limiting access to treatment for patients. As a representative of the pharmaceutical industry, I can tell you the industry is primarily engaged in reimbursement and price control. We are all part of the same system; our goals are aligned with everyone else's to improve access to affordable medicine and procedures.

The way to lower health care costs, including the cost of pharmaceuticals, is to change the personal behavior of patients, rather than simply tinker with reimbursement mechanisms in the name of reform. Emphasizing the importance of personal behavior as a primary determinant of one's health is, however, a discussion that many health care professionals are reluctant to have. For example, when meeting with patients, doctors must be willing to discuss issues of overweight and recommend wellness programs, distribute wellness charts, and advocate for smoking cessation programs. This "grass-roots dialogue" will improve trends and ultimately change the way health care is delivered. This is why the pharmaceutical industry is promoting wellness programs. The cost benefits to employers are demonstrable, making it a far better approach than the usual "patchwork" adjustments.

Preserving and enabling innovation so that there can be new medications for orphan diseases is a priority for us. For example, there are new procedures and treatments that are less invasive for an individual with heart disease and avoid the need for the patient to go to the hospital. We need to preserve innovation that lowers cost by simplifying procedures and improving medications to lessen hospital days. Today's angioplasty was yesterday's open heart surgery. Our concern is one of prevention, intervention, and innovation.

Adam Stavisky — Senior Vice President, Health and Welfare Consulting, Fidelity Investments

Employers have been constrained by their “now-focus”, i.e., their short-term perspective and reliance on calculations such as Return on Investment (ROI). Encouraging a greater emphasis on prevention in disease management and care management are good things, but “ROI takes time to come to fruition. . . . Absent that longer-term perspective, [corporate benefits managers] are focused on today, focused on nicking away at the plan design” – co-pays, premiums, deductibles – “without trying to cause too much of an uproar on the employee side.” For employers, it is this “reinforcement of today” – annual plan maximums, annual deductibles, and annual enrollment that makes them think in terms of annual decisions rather than adapt the necessary, longer range view. We did a survey of senior HR and financial professionals this past fall asking them what keeps them up at nights – the answer was health care costs. While they would prefer to be focused on account management, succession planning, and retirement program costs, the real driver is health care costs because of the pace at which that is growing. So the corporations are focusing their attention on the folks determining health care benefits and expecting them to address these rising costs. Every HR department is expected to find a way to get those costs under the bar. The 80/20 rule applies to HR as well. 80% of their claims come from 20% of the plan participants. Risk transfer to employees is becoming extreme.

Employers are rethinking the ROI to look at the longer range benefits of care management and disease management. Progressive employers across the country are realizing this and are taking a new look at their total compensation packages, learning how better to educate and communicate with their employees, and rebalancing what they spend in an effort to deal more effectively with these critical societal issues.

Panel Two Discussion

“What Can We Do About It?”

Moderator:

Lori Burgiel — Executive Director, Health Care Administrative Solutions, Inc.

We are certainly in the midst of a looming health care crisis with health insurance premiums rising by 7-9% nationally and more in Massachusetts. At this rate it is felt by economists that by 2016, twenty percent of the gross domestic product (GDP) will be going to health care costs. Ms. Burgiel asked the panel first whether the rising costs are inevitable and if there was anything that could be done about it. First responses showed agreement that the escalating costs are unacceptable although changing the trend will be difficult but doable. In addition, Rick Lord noted that from the employers perspective, it is imperative to change the current scenario or it will impact the future of reform in Massachusetts as well as the economy. Each panelist then addressed what can be done about the health care crisis from their organization’s perspective.

James Bryant — Associate Regional Administrator, CMS Region I

The Congressionally mandated Medicare program serves about 43 million people annually, with about 1 billion claims submitted under fee-for-service reimbursement every year. “Regardless of whether you think those [Medicare] policies are good policies or bad policies, it’s important for you to know that that’s the overlay to any health care debate, because in the truest sense they are established Congressional priorities that are a fact – they are a reality that any health care debate will have to deal with.” Medicare is actively pursuing quality improvement and cost savings initiatives on three fronts: (1) *Claims processing*. CMS is vastly reducing the number of contractors who administer claims nationally, and is tying the award of that work to how they do in terms of reducing payment errors. (2) *Fraud and abuse efforts*. CMS is using recovery audit contractors, paid on a contingency fee basis, to recoup monies erroneously paid. Also, they have instituted a system to evaluate contractors and how they are doing, determining where errors are occurring. “We have reduced the claims paid error rate dramatically, to less than 4.4%

annually,” which has thus far produced a \$13 billion annual savings to the Medicare program. (3) *Re-alignment of quality outcomes and costs*. CMS is actively evaluating multiple demonstration projects and trials nationwide in an effort to identify those quality outcomes in various health care settings that offer the greatest potential cost savings to the Medicare reimbursement system. Such efforts in reporting quality measures and transparency are related to developing an infrastructure to report to Congress and make proposals seeking to realign incentives with quality outcomes.

James Roosevelt, Jr., JD — President and CEO, Tufts Health Plan

At Tufts Health Plan, our vision is based on creating greater access for affordable high quality health care. Relying on evidence based medicine, we have designed many strategies, including health plan strategies, which avoid the overuse, underuse and misuse of health care resources. For example, Tufts Health Plan requires that members complete a 12-month counseling program before undergoing “very risky” bariatric surgery, so they will be “physically and psychologically better prepared” to meet the life-altering challenges presented by electing this procedure. Also, Tufts insists that hospitals performing the surgery meet standards of performance as outlined by national health care organizations. All of which has resulted in improved patient outcomes while maintaining coverage, access, and affordability.

“We can and must identify areas where costs are high and the trends are unsustainable, and design initiatives to change those patterns.” Mr. Roosevelt believes that health plans can be called upon to be creative in benefit design. Health care reform was the most recent best example of looking at how to can make health care as affordable as possible while retaining high quality. In order to keep costs as low as possible, one of the ways Tufts met that challenge was to offer a select network. This approach was informed by market research that showed that people prefer to have a smaller network of hospitals, rather than have lower benefits.

In closing, Roosevelt states that working collaboratively with physicians to develop and encourage practice patterns that are consistent with current medical evidence is essential. We can and we

must identify areas where costs are high and the trends are unsustainable and design initiatives to change those patterns. Relying on evidence-based medicine in select networks are two key strategies to obtain our shared goals of improving care and reducing costs.

Senator Richard Moore — Chairman, Health Care Financing Committee, Massachusetts State Legislature

Senator Moore outlined cost control as a legislative priority as demonstrated by the establishment of the Health Care Quality and Cost Council, under the Massachusetts Health Care Reform Act of 2006 (Chapter 58). “Obviously, just looking at cost doesn’t get you what you need. If you’re going in for open-heart surgery, do you want the cheapest heart surgeon or one who has a pretty good record of outcomes?” Chapter 58 encourages the implementation of low cost insurance programs through The Connector that will contain costs and be creditable, affordable coverage. Senator Moore believes transparency needs to be there in order to help people and providers make the right choices. To look at some of the drivers of cost, the reform legislation established a statewide infection control program modeled after the CDC recommendations. That legislation and other bills are addressing other contributing issues such as medical malpractice reform.

Senator Moore agrees that smoking cessation programs and wellness programs can provide economic incentives for people to do what they already know is the right thing to do. He asserts that for Medicaid rates to approximate Medicare rates, the Commonwealth would first need to be assured that there will be commensurate improvements in quality. Pay-for-performance initiatives and state investments in health information technology will help ensure better quality and greater cost-effectiveness.

Richard Lord — President and CEO, Associated Industries of Massachusetts

Global competitiveness of Massachusetts companies depends on our resolving these health care cost containment issues. Mr. Lord represents the 7,500 employers that are members of Associated Industries of MA who are struggling to provide health care to their employees every day. He believes

that providing health promotion and prevention programs to individuals is an important step that employers can take to address rising health care costs. Mr. Lord actively supports wellness programs, smoking cessation programs, and for those companies able to afford it, on-site health clubs for employees. He applauds companies like EMC for the role that they play, but the reality is that most employers in Massachusetts are small and they don't have the resources, the knowledge, or expertise that a company like EMC has.

Employers have embraced the concept of transparency in health care cost and quality. They are supportive of health care system incentives that are aligned properly and reward providers who give high-quality care. Raytheon and Verizon for example, offer strategies to educate employees to become more knowledgeable consumers who are able (with appropriate economic incentives built into the health insurance products) to direct themselves to high-quality, cost-efficient providers.

AIM strongly supports the initiatives underway in Massachusetts to incorporate information technology into our health care system. Although it will require an investment up front, IT improvements should result in both administrative savings in our health care system, as well as, improvements in patient safety which can lead to reduced costs, too. Lastly, Mr. Lord feels it is incumbent upon employers and groups like AIM to become more vocal when health plans, like Tufts, try to manage the care of their employees in a way that's responsible and reasonable. Even though there was a big backlash to managed care in the mid to late '90's, if we really want to address health care costs today, somebody needs to manage the costs of patients.

Meredith Rosenthal, PhD — *Health Economist, Harvard School of Public Health*

From a public health perspective, Dr. Rosenthal agrees that prevention is perhaps the most compelling strategy for cost control, but it must address prevention of chronic disease which is clearly driving much of the cost crisis. It is important to note, however, that much of the preventive care mentioned at the forum are long-range strategies that will not produce cost-savings in the near future. They are strategies that will pay off in the shift of the population burden of illness long term.

The strategies to contain costs are somewhat constrained by our financing system. The number one cost control concern is payment reform. Dr. Rosenthal feels that capitation does save money and that we are in a place now where we can return to capitation with better risk adjustment, and better ways of using capitation more globally so that providers won't avoid the sickest patients who are most costly. "A thoughtful return to prospective payment," potentially using not capitation alone but also episode-based or case-rate based payment structures, is warranted. Agreeing with Dr. Thorpe, she suggests providing a fixed payment to treat a patient with a set of conditions is a better way to pay for the treatment of chronic illness than a pay-for-service (visit-based) system. "More development in this area is really our best strategy for cost control," states Rosenthal.

Regarding rationing, Dr. Rosenthal believes there is no legitimized decision-making about what we should cover and shouldn't cover, and how we should reimburse for services. Private insurers in a system like ours do not have the legitimacy to come out and say 'bariatric surgery should not be paid for in every instance', without [raising] considerable political problems. She feels that if we as a society want to control costs, we need to get some kind of social consensus, social decision-making that does have legitimacy, to say when, in what situations, and how much are we going to pay for these very expensive new innovations which for some portion of the population may have been shown to be very effective, but as soon as we start providing this kind of care it tends to get delivered to everyone, including those for whom it has very low effectiveness. Rosenthal believes that better decision-making is needed, and if done collectively with some kind of legitimate authority to undertake rationing it won't result in the kind of backlash we saw in the wake of managed care. What she finds frustrating is that none of the things mentioned earlier will have a very dramatic effect on cost control as long as there is no overall brake on the system.

Summary of Suggestions

Kathleen O’Loughlin — President and CEO, Delta Dental of Massachusetts

This is an extraordinarily complex system of care and system of financing that we have here in Massachusetts. We need to move away quickly from incremental patchwork approaches, such as “ratcheting down fees, ratcheting down reimbursement, ratcheting down access” as solutions to the cost problem, and “deal with it on a systematic basis – to look at systems solutions to what is a system problem. There is no one easy fix to all of this.”

Step back and understand the basic premise of today’s panel discussions, Dr. O’Loughlin said: “You can have better quality and lower cost simultaneously. They are not mutually exclusive. Start with that premise.”

On managing risk: “The 80-20 rule applies. . . . You know who the high utilizers are. You can predict it by their lifestyles and their personal behaviors. What can we do to help those people better manage their own behavior in a way is not too invasive in the area of personal freedoms? Everyone has the right to choose. We have to acknowledge that and deal with it.”

On aligning the financing mechanism: “We pay for procedures. When we can move away from that incentive and move toward an outcome-based financing scheme, I think we’ll make great inroads in paying for the outcome, not for the procedures. But in the meantime, you’ve got a real-life private practice system that is the engine driving health care in this country, and you can’t ignore it. . . . We need to figure that out.”

On personal entitlement: “Can we deal with the American perception, the entrepreneurial entitlement perception, that ‘I deserve the best health care at any cost.’? . . . We need to fix that, but in a way that’s not punitive. We need to determine how much does entitlement drive the public’s decision-making. When is enough enough? When is too much not good? . . . How much is one year of life worth in financing terms? We need to talk about these decisions and make these hard choices.”

On Medicare: “The 800-pound gorilla at this table was CMS When the government can’t sustain the cost any more, they will do it through legislation, regulation, and policy implementation. Is the private sector prepared for that? We need to be collaborating with the government in supporting demonstration projects and including our own view of demonstration projects, and trying to get private sources of funding to support those projects.”

Closing Remarks

Bertram Yaffe — President, The Erna Yaffe Foundation

This forum is not a random, one-time event. The Massachusetts Health Council recognizes that true reform – attaining affordable and accessible health care for all the residents of the Commonwealth – is a work in progress, thriving on feedback, dialogue, and, perhaps most important, established criteria by which to evaluate real reform. The Council’s mission is to continue to frame this dialogue and measure progress through our interactive programs and our “Common Health for the Commonwealth” trends reports.

The Massachusetts Health Council and all those present recognize and appreciate the fact that last year the leadership of the Commonwealth enacted a Health Care Reform Law to move us to universal insurance coverage. We also recognize that true reform - attaining affordable and accessible health care - is a work in progress.

Works-in-progress thrive on dialogue, feedback, and - perhaps most of all – criteria by which to evaluate real reform. The rigorous nonpartisan National Coalition on Health Care offers these five principles that define reform:

- Health care coverage and accessibility for all;
- Cost management;
- Improvement of health care quality and safety;
- Equitable financing;
- Simplified administration.

The next two years are critical for the attainment of health care reform in the state. The Massachusetts Health Council’s mission is first to continue to frame this dialogue around these principles through our interactive programs and forums in the coming year. Next, our mission is to continue to evaluate our health status through our biennial “Common Health for the Commonwealth” trends report.

I think there was a true statement today in terms of lowering health care cost and promoting prevention in the short-term. We can't do it. There has to be a long-term commitment to system change.

This will contain the costs in the long run. We need allies among policy makers and all of those influence and control activities within the present system to help us attain new models for success.

Summary of “Table” Recommendation

In addition to the recommendations made by the speakers in their presentations, attendees to the conference likewise were invited to offer their implementable suggestions on how better to control rising health care costs. Allowing for some inevitable overlap, these are listed below in three categories: “public education and incentives,” “administrative reform,” and “policy reform.”

Public Education and Incentives

- Engage consumers more effectively, continually emphasizing self-care and prevention.
- Accentuate preventative care, beginning in early childhood with education/instruction on the value of healthy habits.
- Educate the “system” to the importance of patient-centered care, self-advocacy, timelines, quality of care, available resources and support. Maintain consistency of message throughout.
- Educate consumers regarding healthy, affordable nutritional choices.
- Provide more and better data for consumers on cost and quality.
- Effectuate transparency regarding medical errors and infection rates.

Administrative Reform

- Enter, transmit, and preserve all medical records electronically, resulting in a significant savings in institutional staff allocations.
- Include preventative care coverage (including wellness visits and prescription drugs) in low-cost, quality health care plans, thereby reducing long-term cost of chronic disease management. Use clinical, not administrative, data as basis for payment. Focus on proper delivery of care, not just outcomes.
- Open consumer choice (as covered by insurance) to alternative treatment modalities such as chiropractic and nurse practitioners.
- Adjust co-pays so that they are proportional to the ultimate cost to the system.
- Re-orient medical school curriculums to include focus on prevention and coordination of care. Ensure representation of MDs, RNs, pharmacists, et al. on quality councils.
- Develop a consistent, evidence-based reimbursement structure for disease prevention and chronic disease management.
- Eliminate capitation entirely as a payment mechanism.
- Emphasize prevention, and reimburse providers accordingly. Eliminate “perverse” incentives for providers to treat only sick people.

- Reduce administrative overhead within and across state agencies, which are routinely passed on throughout the entire cost structure (insurers, providers, patients).
- Align level of care with level of science. Too many patients who need only basic primary care are utilizing “intense” locations (e.g., expensive, high-overhead, university-affiliated teaching hospitals) and levels of science.
- Institute a Pay for Performance (P4P) system for developing guidelines-based care, as measured in a comprehensive scorecard.
- Allow alternative providers to offer their full spectrum of services, rather than limiting payment to single capabilities only.
- Institute a universal billing system.
- Rely more on information technology to reduce duplication of care and improve communication between providers.
- Make more and better use of nurse practitioners in primary care, patient education, and disease prevention.

Policy Reform

- Institute tax incentives for companies who install employee’s wellness programs, and insurance incentives for employees who participate in such programs.
- Increase cigarette tax to fund universal health care reform.
- Reintroduce quality physical education in schools in order to reduce childhood obesity. Schools designated as “heart healthy” should be eligible for increased state aid/reimbursement. Link physical education and nutritional education.
- Create and fund a federal institute for cost-effectiveness studies, to develop and enforce decisions on what modalities of care should be covered, based on the evidence.
- Promote clinical guidelines as part of payment reform.