

STRATEGIES FOR IMPROVING THE AFFORDABILITY OF HIGH-QUALITY HEALTH CARE AND COVERAGE



**A REPORT FROM THE
NATIONAL COALITION ON HEALTH CARE
JULY 10, 2018**



Working Together for an Affordable Future

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*The **National Coalition on Health Care** (NCHC), the oldest and most diverse group working to achieve comprehensive health system reform, is a non-partisan 501(c)(3) organization representing more than 80 participating organizations, including medical societies, businesses, unions, health care providers, faith-based associations, pension and health funds, insurers and groups representing consumers, patients, women, minorities and persons with disabilities. Member organizations collectively represent – as employees, members, or congregants – over 150 million Americans.*

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EXECUTIVE SUMMARY

The analytic framework for the Coalition’s work on affordability this past year, and for this report, was originally set out in an essay entitled “A Portfolio Strategy for Affordable Coverage: Disaggregating Problems, Aggregating Solutions.” In that article, the NCHC’s John Rother and Mark Goldberg suggested that strategies for improving affordability should address the full range of factors that drive up costs. They proposed an analytic tool – called a health care cost chain – for separating out the stages at which costs are added to the ultimate costs of coverage.

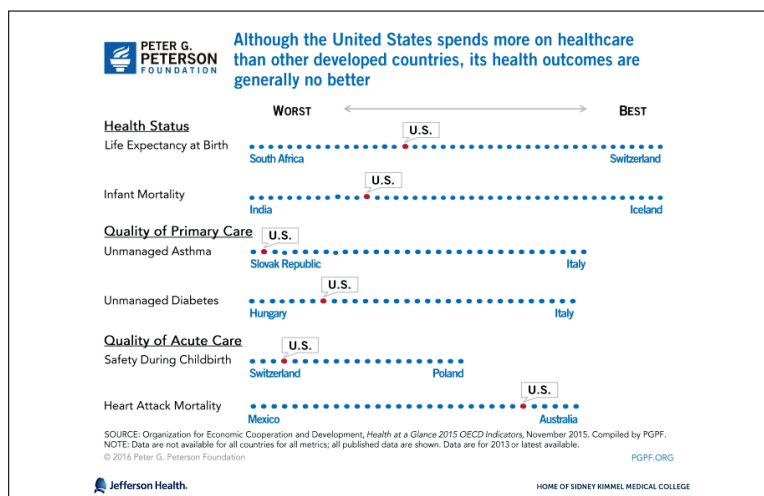
Consistent with that approach and drawing on the literature and regional health care summits convened by the National Coalition on Health Care in cities about the country, this report will identify the impacts and trends that constitute a pressing affordability crisis in America’s health care system today. We will then summarize the drivers of those trends and outline a series of options that could contribute to their management and amelioration.

Impacts and Trends

From 1999 to 2009, health care cost growth wiped out a decade of income gains for the average American family. More recently, families’ spending on health care has continued to grow as spending on transportation, food and housing has shrunk for middle class families. Families are increasingly foregoing care or skipping prescriptions due to cost.

Federal spending on health care is set to climb from 6% of Gross Domestic Product (GDP) to 10.6% of GDP over the next three decades, squeezing out other important priorities. Rising employer costs constrain employers’ ability to invest in increased wages, new business opportunities or expanded employment.

Yet despite these enormous expenditures, the United States’ performance on key health outcomes is falling further and further behind other nations as every year passes.



Slide from Lawrence Ward’s presentation – Philadelphia Summit

Cost Drivers

In recent years, scholarly journals and think tanks have featured robust discussions about varied, often competing accounts of why the United States is facing these rising costs amidst disappointing population outcomes. The participants in NCHC's regional summits offered varied perspectives as well. Synthesizing these perspectives, this report describes several key contributors to the disturbing trajectory of health care costs and outcomes.

- Chronic illness rooted in non-medical determinants of health, attributable both to individual behaviors and certain policy choices that underinvest in prevention and discourage health care institutions from investing in the amelioration of these non-medical determinants;
- Poorly coordinated, inefficient care delivery, driven by direct public subsidies for wasteful services by fee-for-service reimbursement and misaligned incentives that fail to reward those providers, plans or states that manage to deliver better results;
- Misuse of provider market power, which arises when providers in increasingly concentrated markets prop up prices by demanding guaranteed inclusion and anti-steering clauses in provider-plan contracts;
- Barriers to transparency and competition in pharmaceuticals, that produce unsustainable launch prices in new biologic and specialty drugs, year-over-year price increases for on-market brand name drugs, and price spikes in certain low-volume generic and brand name drugs;
- Insurance and reimbursement rules that promote cherry picking of healthier patient populations, which are most immediately apparent in the troubled individual insurance markets as well as in deficiencies in Medicare's risk adjustment and post-acute care payment policies; and
- Cost barriers to high-value care, that ensue, in general, from increasing deductibles and, in particular, from increasing prevalence of High-Deductible Health Plans (HDHPs) associated with Health Savings Accounts (HSAs).

Policy Options

Having explored significant affordability trends and identified six key cost drivers, we offer the following policy options designed to address those drivers.

Focus on Upstream, Non-Medical Interventions

To address the non-medical (i.e. environmental, social, and behavioral) determinants of health, policy-makers should consider:

- A consensus, permanent, bipartisan funding mechanism for prevention initiatives similar to that which supports federal medical research at the National Institutes of Health(NIH);
- A policy framework that supports and encourages individual behavior change, through intensive lifestyle interventions for cardiovascular and endocrine conditions, broader access to evidence-based treatment for substance use, and more aggressive tobacco control;
- Investment in the health of the next generation, including prevention of childhood obesity, tobacco use and substance abuse, testing and scaling of interventions to reduce child exposure to Adverse Childhood Experiences, assuring access to care and evidence-based services in Medicaid and the Children's Health Insurance Program; and

- Removal of policy barriers to upstream investments by health care entities, by promoting population-based provider payment, removing compliance and regulatory barriers to upstream interventions and avoiding restrictions on Medicaid's ability to deploy non-clinical interventions.

Combat Inefficient Care Delivery through Value-based Care

Policymakers need to ensure that volume maximization becomes a less lucrative business strategy than value-based population-based approaches, particularly in traditional Medicare. Toward that end, federal and state policy can

- Continue to maintain pressure on unreformed fee-for-service payment,
- Provide increased upside incentives for delivery innovation by evolving successful payment reform strategies: global payment, health maintenance organizations (HMOs), primary care capitation, and integrated care options for dually-eligible Medicare-Medicaid beneficiaries, and
- Strengthen infrastructure for value-based transformation, by improving alignment of performance measures across payers and strengthening the primary care workforce.

Curb Misuse of Market Power in Provider Markets:

Federal regulators at the Federal Trade Commission should be directed and adequately resourced to police anti-competitive contracting like anti-steering and anti-tiering clauses. State policymakers should consider banning such practices.

Bring Down Barriers to Transparency, Competition and Value in Prescription Drugs

Policymakers should emphasize transparency regarding the value of new drugs compared to existing therapies. Key options in this regard include allowing the Patient Centered Outcomes Research Institute (PCORI) to consider cost, liberalizing manufacturers' ability to share cost information with payers in advance of launch, and emphasizing public access to registry information. At the same time, steps are needed to curtail gaming endemic to the drug approval process, by cracking down on abuses of patents, Risk Evaluation and Mitigation Strategies (REMS) procedures, and orphan drug programs. Strengthening competition from biosimilars is particularly important.

Curb Cherry-Picking and Risk Selection

To stabilize the individual insurance markets, policymakers should pursue

- Federal funding for reinsurance;
- Reconsideration of recent regulatory steps that expand Short-Term Limited-Duration Insurance (STLDI) plans, broaden Association Health Plan (AHP) coverage, and permit states to reduce risk adjustment payments to exchange plans; and
- Strengthening enrollment activities, including through state efforts that automatically enroll certain, subsidy eligible residents in low- or no-cost coverage options.

To address cherry-picking in Medicare, the risk adjustment system for Medicare Advantage plans and Accountable Care Organizations should reflect beneficiaries' functional status and/or LTSS needs and distortions in post-acute care reimbursement should be addressed.

Align Cost-Sharing with Value

The needed transformation of health care payment and delivery must be paired with value-based insurance designs (VBID). Policymakers should recognize that high deductibles are the reality of insurance today and enable plans to cover high-value primary and chronic care services- even before enrollees have spent through the entirety of their deductible.

The Crucial Roles of Public and Private Purchasers and Workers

Public policy helps to structure our health care markets, and Medicare and Medicaid provide coverage to one third of the population. For this reason, the report devotes substantial attention to policy problems and solutions. Nonetheless, employers and workers, working together in the private and public sectors, have a major role to play in addressing the nation's affordability crisis as well. Employer-provided insurance is the source of coverage for 157 million Americans. An aggressive approach by employers and workers is just as crucial as strong public policy.

Innovate aggressively. From the original formation of the HMO by Kaiser Steel to the spread of intensive primary care models for the chronically ill, which date to the Everett Clinic's partnership with Boeing, the delivery and payment models which now provide hope for public programs have roots in disruptive, private sector innovations. A new generation of such initiatives is needed.

Bargain aggressively. While flare-ups between labor and management over health care costs are common, purchasers could consider bringing a similar aggressive spirit to their negotiations with the health care system. Their efforts, whether at a single employer or in coalition with other employers, have the potential to shake loose needed progress. Working together, workers and management can insist on more transparency in drug prices, demand the exclusion of poor-performing providers from tiered or limited networks or pursue reference pricing to tame unjustified price variation in certain services. Once a new drug is approved, purchasers should demand that drugs which make only marginal clinical improvements are not priced the same as breakthrough remedies.

Align aggressively. No idea for transforming care or benefits, whatever its merit, can move the needle in the vast US health care sector, unless others are moving in the same direction. This means that alignment with other private and public purchasers is crucial to the impact of any payment model, performance metric or benefit innovation. It also means engaging with policymakers at the Centers for Medicare and Medicaid Services (CMS) and state capitols to insist that Medicare and Medicaid programs are working hand in glove with purchasers to align their performance metrics and reimbursement models.

INTRODUCTION

This report is the culmination of a year-long program of work designed to help frame, inform, and advance a constructive national dialogue about the affordability of high-quality health care and coverage and about options for improving it. The National Coalition on Health Care greatly appreciates the generous financial support and guidance for this initiative from the Gordon and Betty Moore Foundation.

The analytic framework for our work on affordability this past year, and for this report, was originally set out in an essay by John Rother and Mark Goldberg of the Coalition. In that article – entitled “A Portfolio Strategy for Affordable Coverage: Disaggregating Problems, Aggregating Solutions” – the authors suggested that strategies for improving affordability should address the full range of factors that drive up costs.¹ They proposed an analytic tool – called a health care cost chain – for separating out the stages at which costs are added to the ultimate costs of coverage. “Having disaggregated the problem sets,” they wrote, “we can then generate options for addressing cost drivers in each category....We can increase the probability of success in this context by aggregating solutions – by pursuing a portfolio of strategies designed to slow the rate of increase in costs at every stage of the cost chain.”

With active collaboration and help from many of the Coalition’s 90 national member organizations (who collectively represent over 150 million Americans), and from more than 70 local and state organizations, the Coalition planned and convened major regional forums in seven cities: Chicago, Sacramento, New York, Philadelphia, Atlanta, Los Angeles, and Austin. In each city, we recruited a mix of national and local speakers for formal presentations and moderated discussions about the trends and patterns in the affordability of care and coverage; about categories of underlying cost drivers; and about potential options for addressing the full range of cost drivers to make high-quality care and coverage more affordable. We worked intently to assemble a purpose-built informal network in each catchment area of local and state organizations to help the Coalition and its members generate a robust attendance of senior-level health care decision-makers, thought leaders, and a wide range of stakeholder representatives.

This capstone report draws on findings, insights, and ideas presented and discussed at the regional forums as well as peer-reviewed journals, government reports and a range of other sources. The programs in all of these forums featured formal presentations from nationally recognized experts on health care policy and practice, as well as presentations and panel discussions with leaders from a variety of different organizational settings and professional vantage points in the catchment areas.

Participants in the forums included senior-level leaders and representatives from major provider organizations and associations, large companies, pension funds, health plans, policy and patient advocacy groups, and other key elements in the health care sector.

These forums were designed to inform and catalyze dialogue and to form a strong predicate – of information, insights, and ideas – for this report on options for improving the affordability of high-quality care and coverage. They also functioned as regional hearings – capturing ideas and perspectives from leaders

¹ Mark Goldberg and John Rother, “A Portfolio Strategy For Affordable Coverage: Disaggregating Problems, Aggregating Solutions,” Health Affairs Blog, November 16, 2016, <https://www.healthaffairs.org/doi/10.1377/hblog20161118.057609/full/>

in local health sectors and illuminating significant differences across markets. These differences can have important implications for policymakers and policy, in population health and social determinants, the organization and delivery of care, and the levels and dynamics of competition.

The Coalition hopes that this report will help to inform and frame a constructive, evidence-based national dialogue about how best to improve affordability – which is inextricably linked to health financing sustainability -- and that it will be a useful resource for policymakers, researchers, provider organizations, purchasers, and other stakeholders, nationally and in communities and states around the country. We have posted presentations and other materials, including recordings from the forums, at our web site (www.nchc.org). Agendas for the forums may be found in the appendix to the report.

Over these past months of convening and research, we have learned, and seek to summarize here, a great deal about the impacts of rising costs, about the factors that are driving those increases, and about potential strategies for moderating costs while improving the quality of care. We have also learned, and are heartened to report, that in cities around the country, health care leaders, practitioners, and stakeholders are most strongly motivated not by political or partisan considerations, but by deep commitments to finding ways to help their patients, employees, and neighbors.

We have learned that it is crucial to connect policy and practice – to focus on the ways in which policies can advance or impede the diffusion of best practices.

Additionally, we have learned that it is vital and productive to facilitate dialogue across silos – across categories of organizations, actors, and interests – in order to find strategies and solutions that can work and can endure.

The NCHC team for this program of work consisted of John Rother, the Coalition's President and CEO, and Mark Goldberg, Executive Vice President (co-directors of the project); Larry McNeely, Policy Director; Therese Pollock, Communications Director; Bill Poydence, Operations and Finance Manager; Dedra Benjamin, Meeting Planner; and Marianna Singh, Intern. This project received crucial support, guidance, and engagement from the NCHC Board and its Chairman, Jack Lewin.

We are grateful for financial support, and strategic counsel, from the Gordon and Betty Moore Foundation and to Harvey Fineberg, President; Janet Corrigan, former Chief Program Officer, Patient Care Program; and Beth Berselli, Program Officer, Patient Care. And we are greatly appreciative of the commitment and collaboration of our member organizations and of more than 60 local and state organizations across the country. Many thanks are due also to all of the speakers and expert panelists who contributed so much to the substance, quality, and usefulness of the forums and our collective quest for solutions and to the many hundreds of health care leaders and stakeholder representatives who participated in the forums and will help to carry forward both dialogue and actions.

SECTION 1: Impacts and Trends

Unaffordable Costs

From 1999 to 2009, health care cost growth wiped out a decade of income gains for the average US family.² A more recent analysis concluded that, from 2010 to 2015, average compensation had declined for a full 60% of American workers, when employer and employee premiums and retirement contributions are subtracted from that compensation.³

This erosion of non-health earnings is felt not just in paychecks but also in Americans' standard of living. As illustrated by Figure 1, the dollars spent on health care have increased, while spending on other basic needs has fallen.⁴

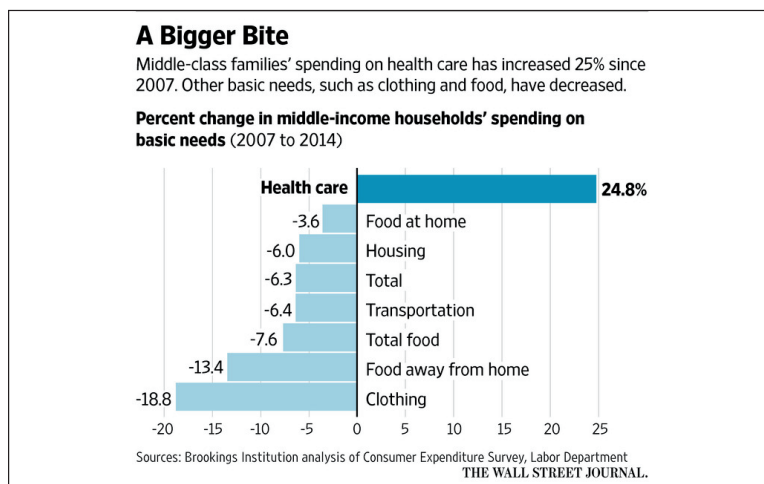


Figure 1: Wall Street Journal, August 25, 2016

In addition to escalating premium costs, deductibles have risen in both employer-sponsored and individually purchased insurance.⁵ Despite success in reducing the percentage of Americans entirely without insurance (see figure 2), underinsurance has risen to 28% of the 18-65 year old population (see figure 3). Underinsurance, as defined by Commonwealth Fund researchers, is the condition of having insurance, but with deductibles greater than 5% of income, out of pocket expenses that are greater than 5% of income for those earning below 200% of the federal poverty level or out of pocket expenses greater than 10% of income for the rest of the population.

2 David I. Auerbach and Arthur L. Kellermann, "A Decade Of Health Care Cost Growth Has Wiped Out Real Income Gains For An Average US Family," Health Affairs, volume 30, no. 9: The Urgency to Lower Costs, September 2011, <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.0585>.

3 Sylvester J. Schieber, "U.S. Health Care: Treating Our Ills, Killing Our Prospects Revisited," presentation for Council for Affordable Health Coverage and American Action Forum, November 1, 2017, <https://www.cahc.net/s/Schieber-CAHC-November-2017-PDF.pdf>.

4 Anna Louise Sussman, "Burden of Health Care Costs Moves to the Middle Class," Wall Street Journal, August 25, 2016, <https://www.wsj.com/articles/burden-of-health-care-costs-moves-to-the-middle-class-1472166246>.

5 Kaiser Family Foundation, "2017 Employer Health Benefits Survey," September 19, 2017, <https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/>. Caroline F. Pearson and Elizabeth Carpenter, "Plans with Restrictive Networks Comprise 73% of Exchange Market," press release, Avalere Health, November 30, 2017, <http://avalere.com/expertise/managed-care/insights/plans-with-more-restrictive-networks-comprise-73-of-exchange-market>.

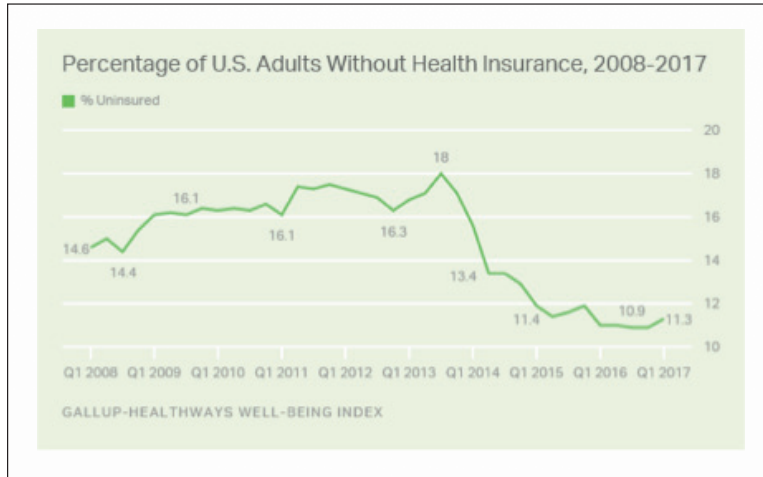


Figure 2: Slide from Ezekiel Emanuel’s presentation - New York Summit

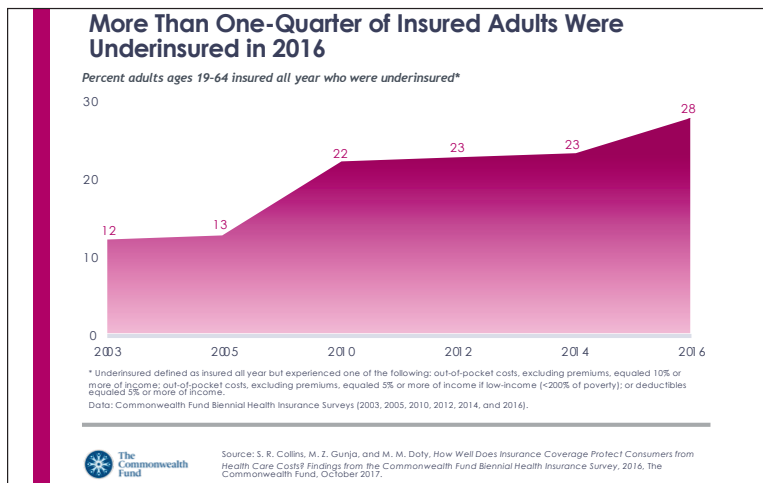


Figure 3: Slide from Sara Collins’ Presentation - New York Summit

A full 52% of these underinsured individuals reported problems accessing care.⁶ This is certainly the case in the individual market for health insurance, where the average silver plan deductible, without cost-sharing assistance, reached \$3937.⁷ Even those enrolled in relatively stable employer-sponsored plans encounter cost barriers that are deterring them from getting necessary care.⁸ Prescription drug costs are the fastest growing component of health care spending, driven by spending on brand name specialty and biologic medications.⁹ In just four years, 2011-2015, Medicare Part D spending on drugs climbed 62%, even after accounting for manufacturer rebates.¹⁰ As with underinsurance, the increasing cost of drugs is having an impact at the point of care. In one poll conducted in 2015, nearly one in four Americans reported that they or a family member had not filled a prescription due to cost.¹¹

6 Sara R. Collins, “How Well Does Insurance Coverage Protect Consumers from Health Care Costs?: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016,” presentation for NCHC’s New York Health Care Summit, November 2, 2017, https://nchc.org/wp-content/uploads/2017/11/Collins_NCHC-Forum-10.30.17.pdf.

7 Pearson and Carpenter, “Plans with Restrictive Networks Comprise 73% of Exchange Market,” November 30, 2017.

8 Collins, “Biennial Health Insurance Survey, 2016.”

9 Gigi A. Cuckler, et.al., National Health Expenditure Projections, 2017-26: Despite Uncertainty, Fundamentals Primarily Drive Spending Growth,” Health Affairs, Vol. 37, No. 3, March 2018.

10 “Increases in Reimbursement for Brand-Name Drugs in Part D,” data brief, U.S. Department of Health & Human Services, June 2018.

11 Bianca DiJulio, Jamie Firth, and Mollyann Brodie, “Kaiser Health Tracking Poll: August 2015,” Henry J. Kaiser Family Foundation, August 20, 2015, <http://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-august-2015/>.

Health care spending is driving up the tax burden borne by Americans as well. 16.9% of the nation’s \$3.2 trillion in health care spending comes from state and local payers, and federal spending is set to climb from 6% of GDP to 10.6% of GDP over the next three decades.¹²

This increasing fiscal burden has consequences for public investments in other pressing priorities. Under current law, federal spending on major health care programs is projected to grow larger than any other category of spending over the next three decades, eclipsing Social Security and discretionary spending on defense, education infrastructure and research.¹³ States’ spending on Medicaid, as a share of overall state spending excluding federal dollars, has grown from 11% in 2000 to 14.6% in 2014 as the share devoted to education, transportation and corrections has shrunk.¹⁴

Employers, both public and private, have felt the impact. From 2006 to 2016, the cost of health insurance premiums for the average family plan jumped 58%. Employers were able to shift a portion of that premium burden to their workers in the form of increased cost-sharing and premiums, but even accounting for that, employers’ costs grew from \$8508 to \$12,865 (see figure 4). These added employer costs constrain employers’ ability to invest in increased wages, new business opportunities or expanded employment.

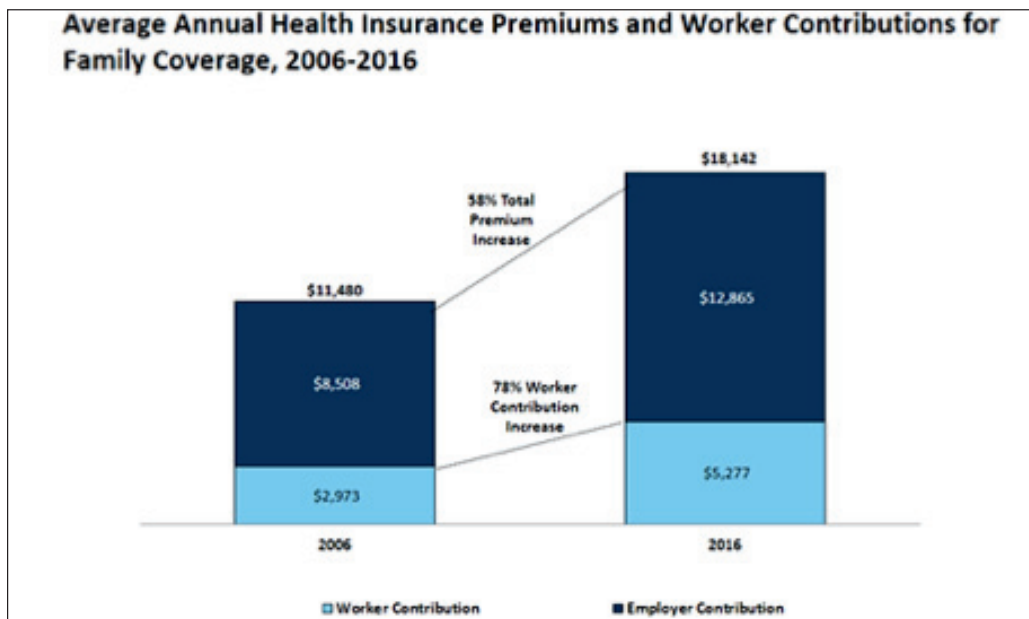


Figure 4: Slide from John Rother’s presentation – multiple summits

Disappointing Outcomes

America’s affordability challenges become even less tolerable when one considers the health outcomes resulting from this enormous investment. While the U.S. has demonstrated better rates of survival from cancer, its performance on several other major health outcome metrics lags behind many other industrialized nations.¹⁵

12 “National Health Care Spending In 2016,” Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE-Presentation-Slides.pdf>.

13 Keith Hall, “Factors Underlying CBO’s Long-Term Outlook for Federal Health Care Spending,” Congressional Budget Office, presentation to the Council for Affordable Health Coverage and the American Action Forum, November 1, 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/presentation/53258-presentation.pdf>.

14 Marc D. Joffe, “Long-Term Trends in Medicaid Spending by the States,” Mercatus Research, Mercatus Center at George Mason University, September 2015, <https://www.mercatus.org/system/files/Joffe-State-Medicaid-Spending.pdf>.

15 Serena Gonzalez and Bradley Sawyer, “How do mortality rates in the U.S. compare to other countries?” webpage from the Peterson Kaiser Health System Tracker, Kaiser Family Foundation, May 22, 2017. <https://www.healthsystemtracker.org/chart-collection/mortality-rates-u-s-compare-countries/#item-mortality-rate-cancers-falling-u-s-across-comparable-countries>.

(see figure 5) Another study concluded that mortality amenable to health care in the U.S. was higher than that of eight other advanced countries.¹⁶

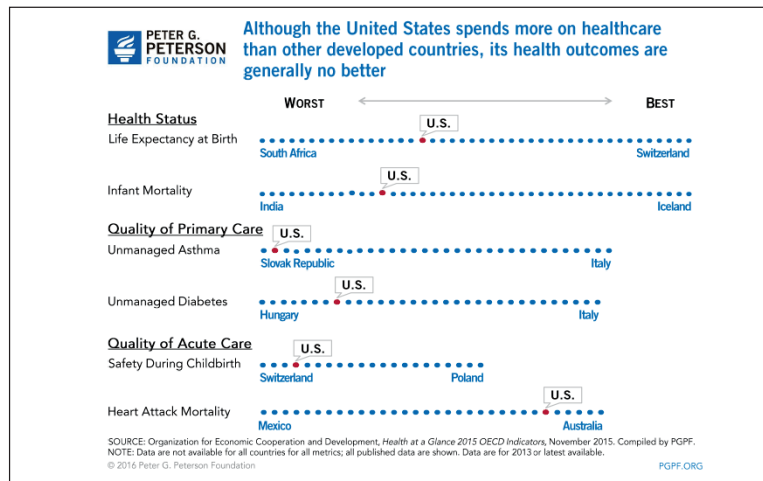


Figure 5: Slide from Lawrence Ward's presentation – Philadelphia Summit

Of even greater concern, this gap in health system performance between US and in other nations is widening. In 1960, life expectancy in the United States exceeded that of every other nation on earth. But over the past half century, US performance on this crucial metric falls further and further behind other nations at the same time that our spending has accelerated further past other advanced nations (see figure 6).

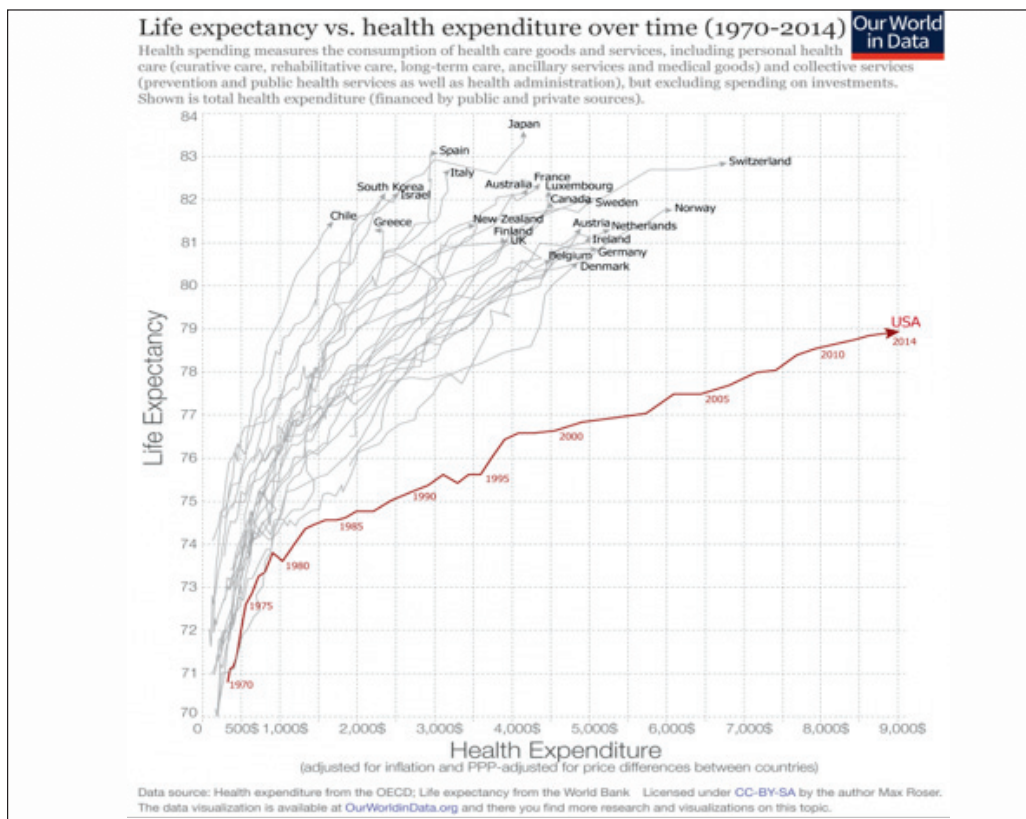


Figure 6: Slide from Ezekiel Emanuel's presentation – New York Summit

16 Gonzalez and Sawyer, "How do mortality rates in the U.S. compare to other countries?" 2017.

SECTION 2: Cost Drivers

In recent years, scholarly journals and think tanks have featured robust discussions about varied, often competing accounts of why the United States is facing rising health care costs amidst disappointing population outcomes. The participants at NCHC's health care summits offered varied perspectives as well. Rather than one single cause, an array of key contributors to our health spending challenges were identified. The following key cost drivers are discussed in detail in this section:¹⁷

- Chronic illness rooted in non-medical determinants of health
- Poorly coordinated, inefficient care delivery
- Misuse of provider market power
- Barriers to transparency and competition in pharmaceuticals
- Insurance rules that promote cherry picking and risk selection
- Cost barriers to high-value care

Chronic Illness Rooted in Non-Medical Determinants of Health

A body of evidence suggests that the rising prevalence of the non-communicable, chronic diseases is at the root of our health care affordability challenges. Notably, an analysis by Ken Thorpe finds that increases in treated prevalence of chronic disease (see figure 7) has accounted for nearly all of the increases in total health expenditures and Medicare spending since 2007.¹⁸

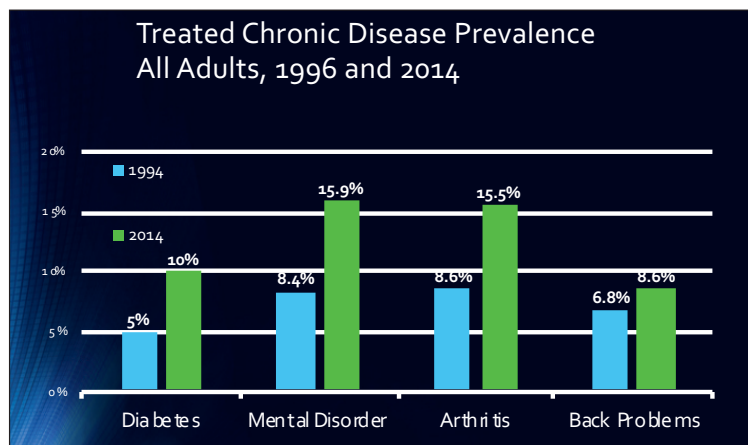


Figure 7: Slide from Kenneth Thorpe's presentation - Atlanta Summit

These chronic disease costs, which drive so much of cost growth, are largely avoidable. The progression of

¹⁷ A careful reader will note that the original Health Affairs Blog piece outlined seven stages in the cost chain, different than the six articulated here. In this report, we opted to reframe these stages to better accommodate the insights the authors identified from the forums. Notably, rather than describing pharmaceuticals and hospital services as input cost, we chose to focus on the market dynamics associated with those products. Further, we found that the incentives for employers and employees were better explained in tandem with cost sharing, as we have done in the section entitled "Cost barriers to high value care" below.

¹⁸ Kenneth E. Thorpe, "Accounting for Health Spending Growth: Observations From the Past Several Years," Health Affairs Blog, March 26, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180321.489080/full/>

pre-diabetes to diabetes to renal disease and other complications is amenable to intervention at multiple points.¹⁹ Strong scientific evidence shows that heart disease is preventable and some studies suggest that through intensive lifestyle intervention, coronary heart disease is reversible.²⁰ Cancer, Alzheimer's disease and some forms of arthritis may be prevented through diet and exercise.²¹ In each of these cases, individual choices about behavior with respect to food and physical activity can affect prevalence, and thereby cost growth (see figure 8).

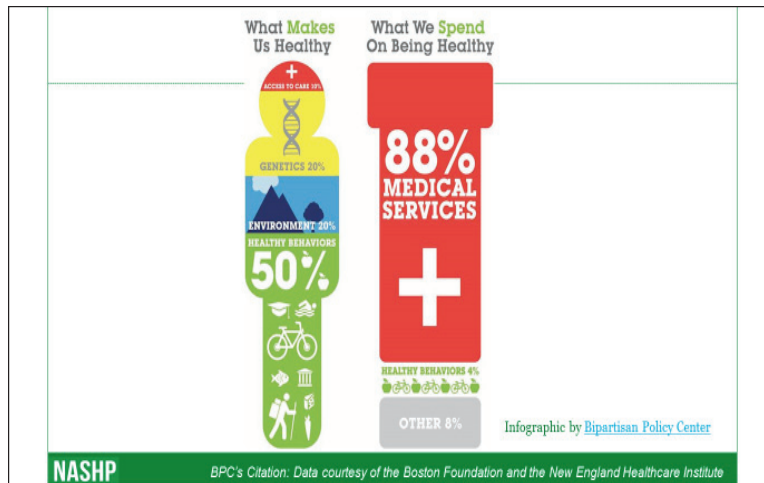


Figure 8: Slide from Trish Riley's presentation – Chicago Summit

However, the most effective ways to combat these preventable chronic diseases go beyond individual actions to encompass the need for public health or community health responses. Raising the price and restricting the availability of tobacco has curbed smoking rates.²² States that invest more in social services relative to health spending exhibit better health outcomes.²³ Counties with higher social service and public health spending also have better outcomes as well.²⁴

Chronic mental health and substance abuse disorders are somewhat different. The United States is confronting a rise in deaths of despair, attributable to alcohol-related cirrhosis, opioid overdose, and suicide.²⁵

Easy access to opioids, in routine medical care for example, appears to have played a role in overdose deaths. Steps are already being taken in regulation and in the market to reduce the problem,²⁶ but it would be hard to argue that lack of healthy eating and exercise are at the root of this public health crisis.

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20 "Preventable Deaths from Heart Disease & Stroke," Centers for Disease Control and Prevention, September 2013, <https://www.cdc.gov/vitalsigns/heartdisease-stroke/index.html>; Dean Ornish, Larry W. Scherwitz, et al., "Intensive Lifestyle Changes for Reversal of Coronary Heart Disease," *Journal of the American Medical Association*, Vol. 280, No. 23, December 16, 1998, <https://www.ornish.com/wp-content/uploads/Intensive-lifestyle-changes-for-reversal-of-coronary-heart-disease1.pdf>.

21 "ACS Guidelines on Nutrition and Physical Activity for Cancer Prevention," American Cancer Society, <https://www.cancer.org/healthy/eat-healthy-get-active/acs-guidelines-nutrition-physical-activity-cancer-prevention.html>; "Prevention and Risk of Alzheimer's and Dementia," Alzheimer's Association, https://www.alz.org/research/science/alzheimers_prevention_and_risk.asp; "How to Prevent Arthritis," Arthritis Foundation, <https://www.arthritis.org/about-arthritis/understanding-arthritis/arthritis-prevention.php>.

22 "Prices, taxes and revenues," Tobacco Free Initiative, World Health Organization, http://www.who.int/tobacco/research/economics/prices_taxes_revenues/en/.

23 Elizabeth H. Bradley, Maureen Canavan, Erika Rogan, Kristina Talbert-Slagle, Chima Ndumele, Lauren Taylor, and Leslie A. Curry, "Variation In Health Outcomes: The Role Of Spending On Social Services, Public Health, And Health Care, 2000–09," *Health Affairs*, Vol. 35, No. 5: Prescription Drugs, Global Health, and More, May 2016, <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2015.0814>.

24 Mac McCullough, Simone Singh, and Jonathon P. Leider, "Local Government Spending and Hospital Health Promotion Activities Are Associated with Better Health Outcomes," abstract of research to be presented at the AcademyHealth Research Meeting, June 25, 2018, <https://academyhealth.confex.com/academyhealth/2018arm/meetingapp.cgi/Paper/25390>.

25 Anne Case and Angus Deaton, "Mortality and Morbidity in the 21st Century," *Brookings Papers on Economic Activity*, Spring 2017, <https://www.brookings.edu/wp-content/uploads/2017/08/casetextsp17bpea.pdf>.

26 "2019 Medicare Advantage and Part D Rate Announcement and Call Letter," Centers for Medicare and Medicaid Services, April 2, 2018, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-02-2.html>.

Nonetheless, providing an environment that makes healthier choices and lifestyles possible is critical to an effective response to these epidemics. The American Society for Addiction Medicine has made clear that “self-management, with mutual support, is very important in recovery.”²⁷ Medications may play an indispensable role in treating opioid use disorders, but public and community health prevention is sometimes necessary to complement medical intervention and make self-management possible.

For example, Housing First interventions, which deploy rental assistance and case management to reduce homelessness, have helped parents with a history of substance abuse to maintain abstinence.²⁸ Supportive employment programs may contribute to relapse prevention for individuals facing substance use disorders and co-occurring mental health conditions.²⁹

Given the success of non-clinical interventions in both addiction and lifestyle-sensitive chronic diseases, the answer to growing chronic disease prevalence is unlikely to be found in doctor visits or hospital stays. Rather, by addressing the social, environmental and behavioral determinants of health, interventions can reduce the likelihood of a disease’s incidence or progression across a population.

Yet the U.S. is simply not making the investments needed to achieve a healthier population. U.S. spending on social services ranks 25th among OECD countries (see figure 9).³⁰

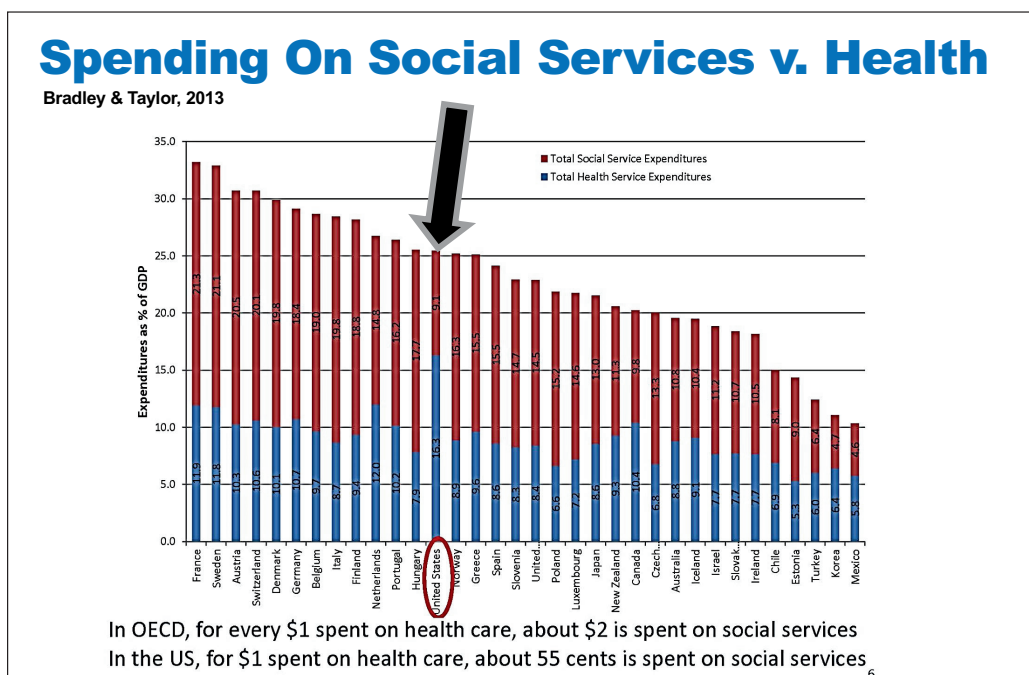


Figure 9: Slide from Georges Benjamin’s presentation - Texas Summit

Public health expenditures accounted for just 3% of the \$3.2 trillion spent on health care generally.³¹

27 “Definition of Addiction,” American Society of Addiction Medicine, website, <https://www.asam.org/resources/definition-of-addiction>.

28 Angela Ly and Eric Latimer, “Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature,” *Canadian Journal of Psychiatry*, Vol. 60, No. 11, November 2015, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679128/>; Susan D. Einbinder and Tanya Tull, “The Housing First Program for Homeless Families: Empirical Evidence of Long-term Efficacy to End and Prevent Family Homelessness,” Institute for Research, Training and Technical Assistance, Beyond Shelter, Policy Brief 1, June 2005, http://partnering-for-change.org/wp-content/uploads/2011/07/Seaver_PolicyBriefExpandedPolicyImplications4.27.09.pdf.

29 Robert E. Drake, Michael A Wallach and Mark P. McGovern, “Special Section on Relapse Prevention: Future Directions in Preventing Relapse to Substance Abuse Among Clients with Severe Mental Illnesses,” *Psychiatric Services*, Vol. 56, No. 10, October 2005, <https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.56.10.1297>.

30 Elizabeth H Bradley, Benjamin R Elkins, Jeph Herrin, and Brian Elbel, “Health and social services expenditures: associations with health outcomes,” *BMJ Publishing Group Limited*, March 29, 2011, <http://qualitysafety.bmj.com/content/qhc/early/2011/03/28/bmjqs.2010.048363.full.pdf?frame=sidebar>.

31 Albert Lang, Molly Warren, and Linda Kulman, “A Funding Crisis for Public Health and Safety: State-by-State Public Health Funding and Key Health Facts,” Trust for America’s Health, March 2018, <http://healthyamericans.org/assets/files/TFAH-2018-InvestInAmericaRpt-FINAL.pdf>.

Instead, the United States' health care spending remains concentrated in acute care settings – which are typically invested in a biomedical model of care that stresses rescue of patients once their conditions have progressed significantly.

Adverse Childhood Experiences' Impact on Outcomes and Costs

The Centers for Disease Control and Prevention identifies early childhood development as one of the social determinants of health. Community and public health work can be most impactful when it includes a focus on children's health.

In particular, work by the Center for Study of Health and Social Policy at the University of Texas has noted that adverse childhood experiences (ACEs) like substance abuse by a family member, abuse, violence in the family or in the community, divorce, or extreme economic hardship can negatively impact future life trajectory (see figure 10).

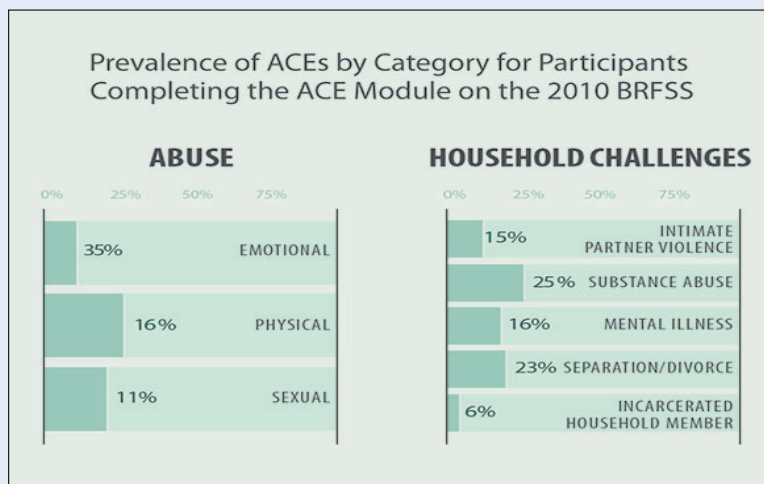


Figure 10: Slide from Cynthia Osborne's presentation – Texas Summit

By contrast, adults reporting better child health have greater active life expectancy, free of disability than those who report poor child health.³²

Clearly, a focus on developing and deploying the interventions that reduce ACEs is key to community health for the long term. Protecting more children from the consequences of abuse, substance use, high divorce rates, and violence is more than a moral imperative; it is fundamental to bending the health care cost curve.

Barriers to Investing Health Care Dollars in Community and Public Health

Notwithstanding the challenges described above, health care leaders have been devoting increasing attention and energy to strategies that address non-medical determinants of health. Were the \$3.2 trillion health sector to shift large-scale resources from biomedical interventions to investments in public health

32 Mark Hayward, "Does The Body Forget: The Long Arm of Childhood," presentation for NCHC's Texas Health Care Summit, March 29, 2018, https://chasp.lbj.utexas.edu/sites/default/files/TXHCSummit032918_FinalWeb.pdf.

and the community, it could have salutary effects on long-term costs while improving outcomes.

However, barriers – which are rooted in policy choices at the national, state and local levels – stand in the way of a substantial shift of health care dollars to public health purposes.

The training of health care professionals, funded heavily by state and local government dollars, is focused largely on medical interventions – not on the crucial intersection of the clinical setting with the community.³³ Federal Medicaid statute requires that states cover institutional care for the infirm or disabled, but home- or community-based care can only be provided through a complex web of waivers.³⁴ Health care providers providing non-medical care or services can run afoul of laws and regulations, like the federal Anti-Kickback, Civil-Monetary Penalty and Physician Self-Referral (Stark) Laws, that were originally designed to forestall increased volume of care under fee-for-service (FFS) payment.³⁵

Addressing each of these barriers will be crucial if the health care sector and health care institutions are to make significant impacts on non-medical determinants of health.

Inefficient Care Delivery

Inefficient care delivery is another key driver of U.S. underperformance on health care costs and quality. The U.S. may not be an outlier compared to other countries in rates of utilization of most services, but a significant proportion of U.S. health spending remains attributable to inefficient delivery of health care services.³⁶

Direct Public Subsidies for Waste

Waste and inefficient health care delivery has been attributed to the United States' reliance on fee-for-service provider reimbursement across payers both public and private.³⁷

FFS reimbursement does have value in certain circumstances. It can serve to expand the quantity of services or goods furnished to patients. Nonetheless, there is a point where further increasing the volume of services or drugs for any individual is not the optimal treatment. At this point, FFS' incentives for ever-increasing volume generate additional costs to families, employers and taxpayers, with sub-optimal or no benefit to patients. In fact, FFS can actually harm patients as a result of over-prescription of drugs, unnecessary tests, or avoidable hospitalizations. In this way, FFS actively drives waste in the health care system in the United States.

Yet today, variants of FFS remain dominant in public programs – despite the enthusiasm around recent progress towards value-based payment. In 2015, Catalyst for Payment Reform concluded that 58% of

33 Federal expenditures on graduate medical education alone exceed \$15 billion a year. This excludes all public investments in non-physician workforce and all state and local GME investments. See the following: Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services, *Graduate Medical Education That Meets the Nation's Health Needs*. Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Washington (DC): National Academies Press (US); September 30, 2014. <https://www.ncbi.nlm.nih.gov/books/NBK248024/>.

34 "Medicaid Coverage of Long-Term Services and Supports," Congressional Research Service, February 28, 2017. https://www.everycrsreport.com/files/20170228_R43328_5834413c5243a128f3e91f6ed70e7e0f074bca6c.pdf.

35 "Health System Transformation: Revisiting the Federal Anti-Kickback Statute and Physician Self-Referral (Stark) Law to Foster Integrated Care Delivery and Payment Models," Healthcare Leadership Council, February 2017, https://www.hlc.org/app/uploads/2017/02/HLC_StarkAntiKickback-White-Paper.pdf.

36 Sarah Kliff, "We spend \$750 billion on unnecessary health care. Two charts explain why," Wonkblog, *The Washington Post*, September 7, 2012, https://www.washingtonpost.com/news/wonk/wp/2012/09/07/we-spend-750-billion-on-unnecessary-health-care-two-charts-explain-why/?utm_term=.a5721c0a0aaf; Nikhil R. Sahni, Anuraag Chigurupati, Bob Kocher, and David M. Cutler, "How the U.S. Can Reduce Waste in Health Care Spending by \$1 Trillion," *Harvard Business Review*, October 13, 2015, <https://hbr.org/2015/10/how-the-u-s-can-reduce-waste-in-health-care-spending-by-1-trillion>.

37 Paul Ginsburg, Meredith Hughes, and Loren Adler, What is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth," Bipartisan Policy Center, September 2012, <http://bipartisanpolicy.org/wp-content/uploads/sites/default/files/BPC%20Health%20Care%20Cost%20Drivers%20Brief%20Sept%202012.pdf>

Medicare payments came through traditional FFS, not value-based mechanisms.³⁸ As of January 2016, CMS estimated that only 39%, or \$117 billion, of the total \$380 billion expended by Traditional Medicare flowed through alternative payment models.³⁹

Misdirected Health Care Workforce Resources

Every year, federal taxpayers invest substantially in the health care workforce. In 2012 alone, that investment totaled \$14.2 billion.⁴⁰ Yet despite the magnitude of these resources, the US has under-invested in the capacity to intervene in the health of populations in the primary care setting. The medical education pipeline has consistently produced fewer primary care physicians than specialists.⁴¹ The US Health Resources and Services Administration (HRSA) projects a growing shortage of primary care physicians (see figure 11).

HRSA: Projected Demand for Primary Care Physicians		
	2010	2020
Total primary care physician <i>demand</i> (FTE)	212,500 ^a	241,200
General ^b	164,400	187,300
Pediatrics	44,800	49,600
Geriatrics	3,300	4,300
Primary care physician <i>supply</i>	205,000	220,800
Supply and demand	(7,500)	(20,400)

^aNational demand projections presented in this report assume that in 2010 the national supply of primary care physicians was adequate except for the approximately 7,500 FTEs needed to de-designate the primary care HPSAs.
^bThis category includes general and family practice, and general internal medicine.

Figure 11: Slide from Lawrence Ward’s presentation – Philadelphia Summit

Of course, real team-based care does not usually depend on asking physicians to personally deliver all of a patient’s care. Advanced practice nurses, physician assistants, nurses, pharmacists, mental health professionals, community health workers, and others all play important roles in delivering frontline primary care. But even among non-physician professions, more than half of physician assistants and slightly less than half of nurse practitioners are employed in specialty rather than primary care settings.⁴²

Misaligned Incentives and the Wrong Pocket Problem

The US health system also suffers from a particular misalignment of incentives, which we will refer to as the “wrong pocket problem.” The wrong pocket problem arises when a particular health care actor shoulders the cost of a particular intervention, but does not receive the benefit.⁴³ In short, this actor has the opportunity to reduce costs and improve value but lacks the incentive to pursue it.

38 “CPR Scorecard on Medicare Payment Reform,” Catalyst for Payment Reform, 2015, <https://www.catalyze.org/product/2015-medicare-scorecard/>.
 39 “HHS reaches goal of tying 30 percent of Medicare payments to quality ahead of schedule,” U.S. Department of Health and Human Services, March 3, 2016, <http://wayback.archive-it.org/3926/20170127191335/https://www.hhs.gov/about/news/2016/03/03/hhs-reaches-goal-tying-30-percent-medicare-payments-quality-ahead-schedule.html>.
 40 “Health Care Workforce: Federally-Funded Training Programs in Fiscal Year 2012,” U.S. Government Accountability Office, August 25, 2013, <https://www.gao.gov/assets/660/656960.pdf>.
 41 Lawrence Ward, “No Outcome, No Income: The Role of Primary Care in the Healthcare Value Revolution,” presentation for NCHC’s Philadelphia Health Care Summit, November 15, 2017, <https://nchc.org/wp-content/uploads/2017/11/Ward-PDF.pdf>.
 42 Stephen M Petterson, et.al., “Relying on NPs and PAs Does Not Avoid the Need for Policy Solutions for Primary Care,” Robert Graham Center, August 15, 2013, <https://www.graham-center.org/rgc/publications-reports/publications/one-pagers/relying-on-nps-2013.html>.
 43 John K. Roman, “Solving the Wrong Pocket Problem,” Urban Institute, November 2015, <https://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000427-Solving-the-Wrong-Pockets-Problem.pdf>.

For example, clinician practices have been able to coordinate patients' often fragmented and duplicative care, reduce avoidable utilization of acute care hospitals, and limit their referrals to high-cost providers.⁴⁴ However, in a straightforward FFS reimbursement structure, they have limited, if any, financial incentives to take these steps. The savings generally accrue to the payer such as the insurance company, or the consumer directly -- not the physician.

Overall, results from Medicare alternative payment models (APMs) have shown some progress toward addressing this particular wrong pocket problem- achieving modest savings among Medicare Shared Savings Program ACOs and substantial savings from bundled payments for hip and knee replacements. But given the limited magnitude of that progress so far, Medicare clearly has yet to adequately address this misalignment.

Another wrong pocket problem appears in the relationship between federal and state governments -- particularly with respect to those Medicare enrollees who, by reason of income or disability, are "dually eligible" for both Medicare and Medicaid (commonly referred to as "dual eligibles"). The provision of appropriate long-term services and supports (LTSS) can reduce downstream hospital and medical costs among those dually eligible beneficiaries.⁴⁵ Behavioral health care services can also prove crucial to avoiding downstream medical costs. Yet because any savings from such interventions would accrue largely to Medicare, which pays for acute care primarily, state Medicaid programs have less incentive to invest in those services than they otherwise might. Cost burdens increase on family caregivers, health care providers and payers, who must shoulder the increased system-wide costs that result from gaps in these services.

Here too, diverse state strategies to address this wrong pocket problem have been undertaken, with some promising, if not yet game-changing, results. The Medicaid Health Home program, which provides enhanced federal funds to states that provide integrated behavioral and physical health care, has yielded some promising early results in Washington and Missouri.⁴⁶ Minnesota has had positive results among dually eligible Medicare-Medicaid enrollees by pairing Medicare Advantage Dual Eligible - Special Needs Plans (D-SNPs) and Managed Long-Term Services and Supports (LTSS) Medicaid plans provided by the same parent insurance carrier.⁴⁷ Under the ongoing Financial Alignment Demonstrations, Medicare-Medicaid Plans (MMPs) manage the full range of physical, behavioral, prescription drug, long-term care and wraparound services to which dual eligibles are entitled. Preliminary data for three Financial Alignment Demonstration states show a reduction in nursing facility use.⁴⁸ One major national insurance plan successfully transitioned more MMP enrollees to home-based care from institutions.⁴⁹ All these approaches indicate promise, but, here, as with the adoption of APMs in Medicare, current evidence in no way suggests that policymakers have solved this wrong pocket problem.

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- 44 Ashish K. Jha, et. al., "Care Fragmentation, Quality and Costs Among Chronically Ill Patients," *American Journal of Managed Care*, May 2015, <http://www.ajmc.com/journals/issue/2015/2015-vol21-n5/care-fragmentation-quality-costs-among-chronically-ill-patients>; M. Van Hasselt, N. McCall, V. Keyes, S.G. Wensky, and K.W. Smith, "Total Cost of Care Lower among Medicare Fee-for-Service Beneficiaries Receiving Care from Patient-Centered Medical Homes," *Health Services Research*, Vol. 50, No. 1, February 2015, <https://www.ncbi.nlm.nih.gov/pubmed/25077375>; Robert E. Mechanic, Palmira Santos, Bruce E. Landon, and Michael E. Chernew, "Medical group responses to global payment: early lessons from the 'Alternative Quality Contract' in Massachusetts," *Health Affairs*, Vol. 30, No. 9: The New Urgency to Lower Costs, September 2011, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0264>.
- 45 Jean Accius and Brendan Flinn, "Stretching the Medicaid Dollar: Home and Community-Based Services Are a Cost-Effective Approach to Providing Long-Term Services and Supports," AARP Public Policy Institute, February 2017, <http://www.aarp.org/content/dam/aarp/ppi/2017-01/Stretching%20Medicaid.pdf>.
- 46 Edith Walsh, "Report for Washington Managed Fee-For-Service (MFFS) Final Demonstration Year 1 and Preliminary Demonstration Year 2 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative, Prepared by RTI International for CMS, July 13, 2017, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalMedicareCostYr1FinalYr2Preliminary072817.pdf>; "Missouri CMHC Health Homes: Progress Report," Missouri HealthNet, 2017, <https://dmh.mo.gov/mentalillness/provider/docs/cmhchchreport16.pdf>.
- 47 *Minnesota Managed Care Longitudinal Analysis*, Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services, March 2016, <https://aspe.hhs.gov/system/files/pdf/204996/MNmclda.pdf>.
- 48 Joyce Wang, et.al., "Early Evidence on Nursing Facility Utilization in Demonstrations Under CMS's Financial Alignment Initiative, abstract of research to be presented at the AcademyHealth Research Meeting , June 25, 2018, <https://academyhealth.confex.com/academyhealth/2018arm/meetingapp.cgi/Paper/25479>.
- 49 Response to CMS Innovation Center New Direction Request for Information, Molina Healthcare, <https://innovation.cms.gov/files/cmmi-newdirectionrfi-responses.pdf>.

Alternative Payment Models in Traditional Medicare: Results so Far

To date, the best analysis of the Medicare Shared Savings Program's Accountable Care Organizations (ACOs) suggests approximately 1.6% savings yearly, compared to a similar population not in ACOs.⁵⁰

Some analyses of MSSP results appear less impressive when program savings are compared to payment benchmarks, which are established for policy reasons, not actual spending in absence of the ACO.⁵¹ But even measured against these artificially low benchmarks, MSSP savings increase as participants continue in the program and when they move to accept downside risk.⁵² Figure 12 below provides a comparison of results among Medicare ACO programs, albeit one measured solely against payment benchmarks.⁵³

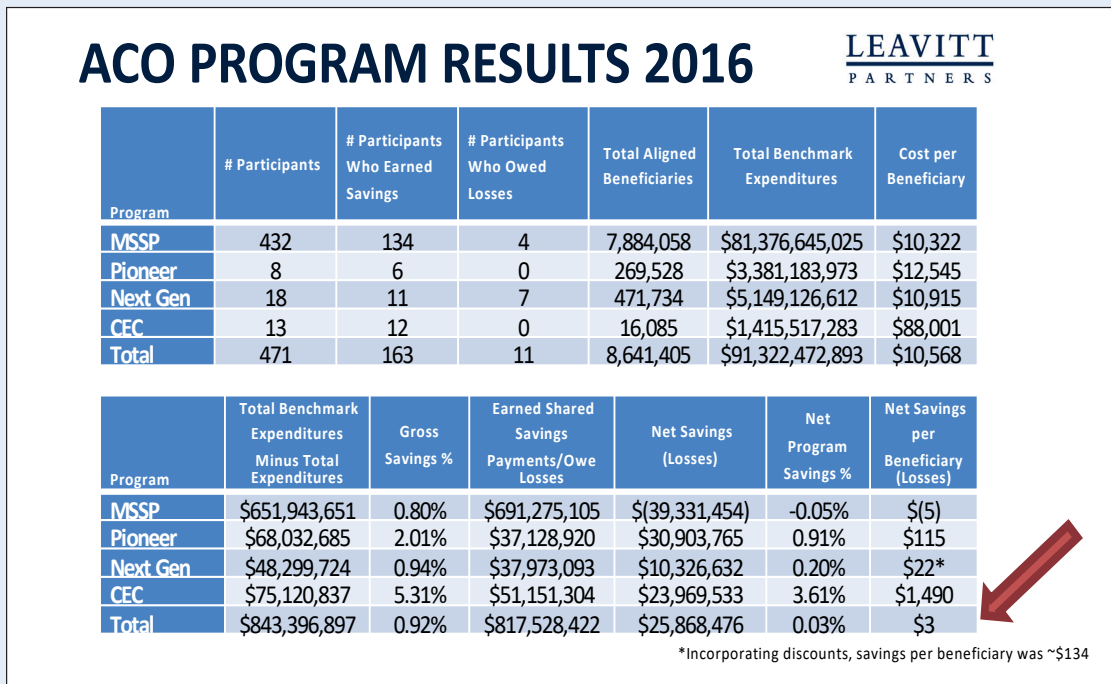


Figure 12

- 50 J. Michael McWilliams, "Savings from ACOs—Building on Early Success," *Annals of Internal Medicine*, Vol. 165, No. 12, October 11, 2016, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5237631/>.
- 51 Michael E. Chernew, Christopher Barbey, J. Michael McWilliams, "Savings Reported by CMS Do Not Measure True Savings," Health Affairs Blog, June 19, 2017, <https://www.healthaffairs.org/doi/10.1377/hblog20170619.060649/full/>.
- 52 "Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential For Reducing Spending and Improving Quality," HHS Office of Inspector General, August, 2017, <https://oig.hhs.gov/oei/reports/oei-02-15-00450.pdf>.
- 53 David Muhlestein, "Alternative Payment Models: Achieving the Next Level of Performance," Leavitt Partners, presentation at NCHC Capitol Hill Forum, March 16, 2018, <https://nchc.org/wp-content/uploads/2018/03/Muhlestein-PDF.pdf>

Episodic bundled payments have yielded more substantial savings in the delivery of the most common surgeries, knee and hip replacements, without evident degradation of quality. (see figure 13)

Bundle	Savings per case (relative to comparison group)	% Savings (relative to comparison group)
Joint replacement	\$1,273 (model 2)	4.5% (model 2)
	\$2,568 (model 3)	7.1% (model 3)
Heart failure	\$970 (model 3)	3.6% (model 3)
38 other bundles	No significant difference	No significant difference

Figure 13

Cost savings failed to materialize from the first large scale tests of advanced primary care in Medicare (the Comprehensive Primary Care and Multi-payer Advanced Practice Demonstration). However, CMS has launched a new model in 2017 with sharper incentives for participating practices.

Misuse of Provider Market Power

In 90% of Metropolitan Statistical Areas (MSAs), the hospital markets are highly concentrated – using categories defined by federal antitrust regulators. The proportion of MSAs with highly concentrated specialty and primary care markets is lower, at 65% and 39% respectively.⁵⁸

Concentration in any particular market does not preclude the possibility of high-value care. Some of the lower-cost regions of the U.S., such as Salt Lake City, Utah and Eau Claire, Wisconsin, have highly concentrated provider markets. In both of these examples and others, dominant provider systems may actually play a role in restraining cost growth and improving outcomes. Some regions may not have the populations necessary to support three or more general or acute care hospitals.⁵⁹

54 “CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report,” The Lewin Group, October 17, <https://downloads.cms.gov/files/cmimi/bpci-models2-4yr3evalrpt.pdf>.

55 David Muhlestein, “Alternative Payment Models: Achieving the Next Level of Performance,” March 16, 2018.

56 Deborah Peikes, et al., “The Comprehensive Primary Care Initiative: Effects on Spending, Quality, Patients, And Physicians,” *Health Affairs*, Vol. 37 No. 6, June 2018; “Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Final Report,” evaluation prepared for Centers for Medicare and Medicaid Services, RTI International, June 2017

57 Len M. Nichols, “Payment Reform 3.0: It’s Time,” presentation for NCHC’s Philadelphia Health Care Summit, November 15, 2017, https://nchc.org/wp-content/uploads/2017/11/Nichols_NCHC-PDF.pdf.

58 Brent D. Fulton, “Health Care Market Concentration Trends In The United States: Evidence and Policy Responses,” *Health Affairs*, Vol. 36, No. 9, September 2017, <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0556>.

59 Kevin Griffith, “The Feasibility of Managed Competition for Hospital Services,” abstract of research to be presented at the AcademyHealth Annual Research Meeting, June 25, 2018, <https://academyhealth.confex.com/academyhealth/2018arm/meetingapp.cgi/Paper/25302>.

However, elsewhere, and in general, market power is associated with higher prices.⁶⁰ Nationwide, the average price for inpatient admissions, charged to private plans, exceeds Medicare rates by 89%, and certain Indiana markets exhibit outpatient rates that are 358% of Medicare reimbursement.⁶¹ Medicare has the power to effectively set prices for hospital services, but other payers face enormous variance and variation in prices depending on the leverage exerted by providers.

The mechanisms whereby these high prices are secured include a variety of tying mechanisms that leverage a provider's market power in one geography or type of service to raise prices or volume elsewhere.⁶²

So-called "guaranteed inclusion" clauses are one example of these anti-competitive mechanisms. These provisions allow health systems anchored by hospitals or providers in high demand to force health plans to include the remainder of the health system in their coverage network. This protects costly, poor-performing providers from exclusion from plans' coverage networks.

Anti-steering clauses are another such provision. Payers sometimes assign providers to differing cost-sharing tiers in order to encourage enrollees to seek care at a provider who has agreed to a lower price or provides better care. Health systems with significant market power can insist on contract clauses that prevent this kind of steering and tiering. These clauses frustrate the ability of health plans and employers to exclude lower-performing or higher priced providers from their network, effectively insulating the health system from competition.

In a concentrated environment, these contracting practices serve to prop up prices and insulate the incumbent from potential competitors.⁶³ Unfortunately, lawmakers and regulators at both the federal and state level have often failed to curtail their use.

Barriers to Transparency and Competition in Prescription Drugs

Today the market for prescription drugs is failing to constrain prices in crucial respects. It is failing to restrain launch prices of new, brand name drugs. It is failing to curb the growth of list prices over time once a brand name drug has entered the marketplace. (See Figure 14 next page)

60 Zack Cooper, Stuart V. Craig, Martin Gaynor, and John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, May 7, 2018, http://www.healthcarepricingproject.org/sites/default/files/20180507_variationmanuscript_O.pdf

61 Jared Lane Maeda and Lyle Nelson, "An Analysis of Private-Sector Prices for Hospital Admissions," Working Paper Series, Congressional Budget Office, April 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/52567-hospitalprices.pdf>; Kelly Gooch, "RAND: Average price for outpatient hospital care in Indiana 358% of Medicare rate," *Becker's Hospital CFO Report*, September 8, 2017, <https://www.beckershospitalreview.com/finance/rand-average-price-for-outpatient-hospital-care-in-indiana-358-of-medicare-rate.html>. Even if one argues Medicare rates are artificially low, variance of this magnitude suggests that market power is at work.

62 Barak D. Richman, "Beyond Repeal and Replace: Concentration in Health Care Markets: Chronic Problems and Better Solutions," American Enterprise Institute, June 2012, http://www.aei.org/wp-content/uploads/2012/06/-concentration-in-health-care-markets-chronic-problems-and-better-solutions_171350288300.pdf.

63 Martin Gaynor, Farzad Mostashari, and Paul Ginsburg, "Making Health Care Markets Work: Competition Policy for Health Care," The Leonard D. Schaeffer Initiative for Innovation in Health Policy, April 2017, <https://www.brookings.edu/wp-content/uploads/2017/04/gaynor-et-al-final-report-v11.pdf>.

Rising Prices After Drug Launch

Top selling U.S. drug prices over five years

Prices rose 54 percent to 126 percent.

DRUG (COMPANY)	PRICE*		PRICE GROWTH
	Dec. 31, 2010	Present	
Humira (AbbVie) 40 mg/0.8 ml pre-filled syringes	\$1,676.98	\$3,797.10	126.4%
Enbrel (Amgen) 50 mg/ml subcutaneous sol.	\$427.24	\$932.16	118.2%
Copaxone (Teva) 20 mg/ml subcutaneous sol.	\$3,025.04	\$6,593.00	118.0%
Crestor (AstraZeneca) 10 mg tablets	\$350.17	\$745.41	112.9%
Abilify (Otsuka) 10 mg tablets	\$454.07	\$891.97	96.4%
Lantus Solostar (Sanofi SA) 100 units/ml subcutaneous sol.	\$191.96	\$372.76	94.2%
Advair Diskus (GlaxoSmithKline) 250/50 inhalation discs	\$199.90	\$334.63	67.4%
Remicade (Johnson & Johnson) 100 mg IV powder for solution	\$657.87	\$1,071.48	62.9%
Neulasta (Amgen) 6 mg/0.6 ml subcutaneous sol.	\$3,320.00	\$5,155.65	55.3%
Nexium (AstraZeneca) 10 mg oral packets	\$162.55	\$250.94	54.4%

* Reflects wholesale acquisition prices before volume-related rebates and other discounts. Prices are based on most commonly prescribed dose.
Source: Truven Health Analytics

Figure 14: Slide from James Robinson's presentation – Southern California Summit

On the other end of the cost spectrum, market failures extend to a subset of generics and low-volume brand name drugs. These drugs, typically available from a single manufacturer, are vulnerable to sudden, substantial price increases.

It is little wonder that prescription drug costs are the fastest growing component of health care spending.⁶⁴ The U.S. is now experiencing cost growth that outpaces the savings associated with patent expiries and associated brand competition (see figure 15).

64 Aaron Berman, et. al., *Curbing Unfair Drug Prices: A Primer for States*, Global Health Justice Partnership of the Yale Law School and the Yale School of Public Health, National Physicians Alliance, and Universal Health Care Foundation of Connecticut, August 2017, https://law.yale.edu/system/files/area/center/ghjp/documents/curbing_unfair_drug_prices-policy_paper-080717.pdf.

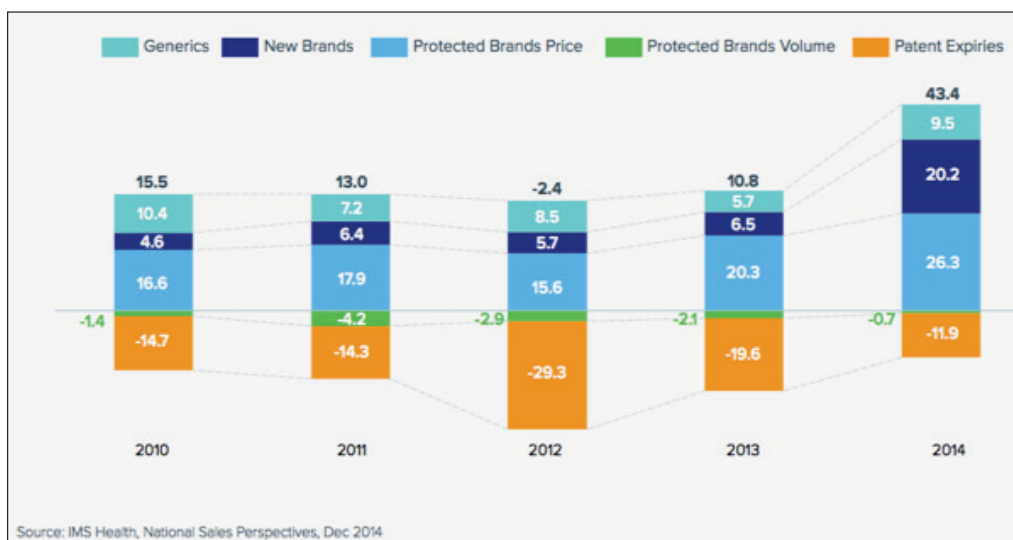


Figure 15: Slide from Gerard Anderson's presentation – Chicago Summit

In any well-functioning market, information relevant to value must be transparent to the buyer as well as the seller. Currently, this fundamental condition is lacking in pharmaceuticals in the U.S. – both brand and generic.

There is far too little transparent information available about either the price of a new medication or its effectiveness relative to existing therapy. FDA approves medications for sale based on demonstration that a medication is safe and effective compared only to a placebo; evaluating the effectiveness of the drug relative to competing medications is not part of its statutory responsibilities. Payers who seek information on relative effectiveness must cobble together studies performed for foreign regulators and, when available, studies by private organizations like Institute for Clinical and Economic Review (ICER). Lack of basic information on the value of a product would be a cause for concern in any marketplace. But in pharmaceuticals, that is not the only problem.

Another key condition of a functioning market is the ability of a buyer to seek the chosen product from another seller. Often, this condition is absent as well-and it is absent in large part because of the policies that shape the prescription drug market.

In the U.S., the granting of monopoly market power is actually fundamental to the market for new prescription drugs. To reward innovators, federal patent law grants an individual or firm the right to exclusively sell or license the sale of many products, including drugs. These patents effectively grant a monopoly on the use of a particular innovation. But because the process of securing Food and Drug Administration approval to sell a prescription drug can often consume much of a patent period's protection, food and drug law provides additional protections from generic competitors over and above patent law – typically five years for the brand name manufacturer of most chemical drugs. The aim is to provide a balance between innovation and affordability.⁶⁵

Brand Name Drugs

Unfortunately, in 2018 the intended balance is sorely lacking. Regulators and lawmakers have established, permitted and protected rent-seeking practices that serve to further constrict or delay competition against brand name drugs.

65 "Administering the Hatch-Waxman Amendments: Ensuring a Balance Between Innovation and Access; Public Meeting; Request for Comments," US Food and Drug Administration, June 14, 2017, <https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-12641.pdf>

For example, brand companies today often employ a practice known as evergreening – whereby a company can effectively extend patent or exclusivity protection indefinitely.⁶⁶ A small shift in the mode of administration or the combination of one drug with another can permit the same company to market the same drug with the attendant patent and market exclusivity monopoly protections. The largest grossing medication now on the market, the rheumatoid arthritis drug Humira, has over 100 patents, the longest of which expires in 2034.⁶⁷ Recently, one manufacturer sold its patent to a Native American tribe, using that tribe’s sovereign immunity from suit to stymie challenges to the patent.⁶⁸

So-called pay for delay arrangements represent another potential barrier to competition. These are agreements whereby an incumbent manufacturer provides various forms of consideration, often including monetary compensation, to delay the entry of a generic competitor into the market. According to the Federal Trade Commission, the impact of these deals on federal taxpayers alone totals \$3.5 billion a year.⁶⁹

Specialty and Biologic Medications

The gaming is not confined to the patent and approval process; it has reached federal statute – particularly with respect to specialty, provider-administered and biologic drugs. Congress has established additional exclusivity periods and approval pathways for brand name manufacturers of certain kinds of medications, and the industry has responded by concentrating their new drug development in these areas.

Examples include additional periods of exclusivity for so-called “orphan drugs” substances that failed to achieve approval for one condition but are repurposed to treat other ailments. While the original aim of the orphan drug law may have been to provide new care options to patients, the price for a year of an orphan drug averages \$111,820, compared to \$23,331 for mainstream drugs.⁷⁰

Perhaps most notably, federal statute now grants a twelve-year exclusivity period for medicines derived not from the mixture of chemical compounds, but grown from biological sources. The analogous period for chemical drugs is five years.⁷¹

Additionally, the way in which these drugs are distributed also works to forestall competition from generics. For example, some brand name drug companies have used FDA protocols designed to prevent diversion of powerful or dangerous drugs, called Risk Evaluation and Management Strategies (REMS), to deny samples of drugs to potential generic competitors. This practice along with other restrictive drug distribution channels may be costing the U.S. up to \$5.4 billion a year system-wide.⁷²

Generic Drugs

Where multiple generic competitors exist, the U.S. market yields lower prices for generic drugs than are available in Canada. Unfortunately, failures in the competitive market for generic drugs remain common—especially for lower-volume or older generics.

66 “Patent Evergreening: Issues in Innovation and Competition,” Congressional Research Service, November 13, 2009, <https://www.everycrsreport.com/reports/R40917.html>.

67 “Ensuring the Future of Accessible Medicines in the U.S.: Avoiding Shortages & Ensuring Competition for America’s Patients,” Association for Accessible Medicines, February 2018, <https://www.accessiblemeds.org/sites/default/files/2018-02/AAM-Whitepaper-Ensuring-Future-of-Generic-Medicines.pdf>.

68 “Biosimilars Council Policy Recommendations to Develop a Robust Biosimilars Market in the U.S.,” Association for Accessible Medicines and The Biosimilars Council, April 2018, <https://www.accessiblemeds.org/sites/default/files/2018-04/AAM-Biosimilars-Council-Policy-Recommendations-Biosimilars-4-2018.pdf>.

69 “Pay for Delay: When Drug Companies Agree Not to Compete,” Federal Trade Commission, <https://www.ftc.gov/news-events/media-resources/mergers-competition/pay-delay>.

70 Sarah Jane Tribble and Sydney Lupkin, “Sky-High Prices For Orphan Drugs Slam American Families and Insurers,” Kaiser Health News, January 17, 2017, <https://khn.org/news/sky-high-prices-for-orphan-drugs-slam-american-families-and-insurers/>.

71 “Policy Proposal: Reducing the Exclusivity Period for Biological Products,” fact sheet, Pew Charitable Trusts, September 8, 2017, <http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2017/09/policy-proposal-reducing-the-exclusivity-period-for-biological-products>.

72 Alex Brill, “Lost Prescription Drug Savings from Use of REMS Programs to Delay Generic Market Entry,” Matrix Global Advisors, July 2014, http://www.gphaonline.org/media/cms/REMS_Studyfinal_July2014.pdf.

For some of the drugs with low sales volume or that have been available for many years, firms have adopted the strategy of purchasing existing manufacturers in order to achieve a monopoly for a particular drug and thereafter raise prices. There are few restraints on price gouging when a manufacturer tries to maximize short term profits. This strategy remains in use despite substantial controversy and headlines. Public shaming alone appears insufficient to curtail price spikes that arise from the market’s structure.

Insurance and reimbursement rules that promote cherry-picking and risk selection

Functioning markets ought to encourage health plans and providers to deliver the best health care value – quality care at an affordable price. But in U.S. health insurance markets, and certain provider markets, that is not always the driving incentive. Instead, incentives remain to construct business plans around enrolling healthier, lower-cost populations – not on delivering better care to the high-cost, high-need beneficiaries in which health spending is concentrated.

In state individual insurance markets, there is evidence of risk selection – despite the ban on medical underwriting and market rules designed to limit this practice. This plays a role in the broader affordability challenges in these markets – as healthier enrollees forego insurance or purchase coverage elsewhere (see figure 16).

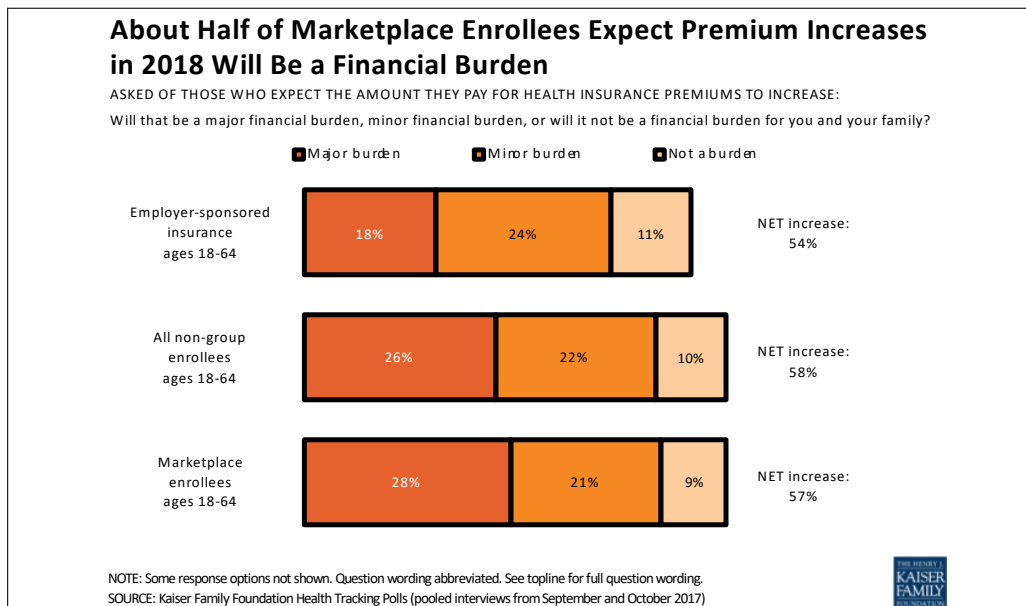


Figure 16: Slide from Jennifer Tolbert’s presentation – Georgia Summit

Recent attempts to support alternative coverage arrangements may be poised to make this challenging situation worse by further fragmenting the market for individually purchased insurance. Of particular concern are efforts to promote short-term, limited duration insurance and association health plans (AHPs), advanced by federal regulators in 2018.⁷³ In contrast to comprehensive individual market insurance sold both on and off the ACA’s state health insurance exchanges, these short-term and association plans are exempt from the federal essential health benefit and underwriting protections enacted in 2010.

73 “Proposed Rule: Short-Term, Limited-Duration Insurance,” Internal Revenue Service, Employee Benefits Security Administration, Centers for Medicare and Medicaid Services, published February 21, 2018, <https://www.gpo.gov/fdsys/pkg/FR-2018-02-21/pdf/2018-03208.pdf>; “Proposed Rule: Definition of ‘Employer’ Under Section 3(5) of ERISA-Association Health Plans,” January 5, 2018, <https://www.federalregister.gov/documents/2018/01/05/2017-28103/definition-of-employer-under-section-35-of-erisa-association-health-plans>

One Avalere analysis finds that AHPs, with lower premiums, could siphon between 3.2 million consumers from the existing insurance markets by 2022. This would necessitate corresponding 3.5% premium increases in the exchanges and off-exchange individual markets.⁷⁴ Another analysis concluded that between 1.07 million and 1.95 million fewer consumers would enroll in ACA-compliant plans, following full implementation of the proposed expansion of STLDI plans.⁷⁵ A separate study projected that 2.2 million consumers in 2019 would move to short-term plans.⁷⁶ Taken together, the AHPs and STLDI plans have the potential to impair stability of the existing insurance markets and impose significant premium costs on individual market consumers.

Unfortunately, risk selection challenges exist beyond the troubled individual insurance markets. Risk segmentation and selection also persists in more politically stable and more profitable health insurance markets, like Medicare Advantage. Medicare Advantage's risk adjustment system, adjusting payment based on certain clinical diagnoses, has largely curtailed cherry-picking of healthy seniors at enrollment. But after patients have enrolled, some plans' cost-sharing may encourage disenrollment of certain beneficiaries, particularly those with long-term care needs.⁷⁷ This should be unsurprising given that Medicare's risk adjustment system does not directly factor in long-term care use or the presence of functional limitations (short of outright disability), and under-predicts costs associated with those enrollees.

Of course, the practice of cherry-picking is not confined to health plans. In Medicare post-acute care provider payment, nursing homes and home health agencies have incentives to seek out healthier Medicare customers who require more therapy services, rather than those with more complex care needs.⁷⁸

Cost Barriers to High-Value Care

As noted above, deductibles have been rising across commercially purchased and employer sponsored coverage. This cost burden has led to both increasing pressures on employers' bottom lines and further shifting of the cost of employer-sponsored insurance costs onto employees (see figure 17). But in addition to being a trend by which we define our affordability challenges, the rise of high deductible health plans (HDHPs), particularly high deductible insurance associated with a Health Savings Account (HSA), could be a cost driver in its own right.

74 Dan Mendelson, Chris Sloan, and Chad Brooker, "Association Health Plans Projected to Enroll 3.2M Individuals," Avalere, February 28, 2018, <http://avalere.com/expertise/managed-care/insights/association-health-plans-projected-to-enroll-3.2m-individuals>.

75 Michael Cohen, Michelle Anderson, and Ross Winkelman, "Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market," Wakely Consulting Group, <http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-Limited-Duration-Plans-Report.pdf>.

76 Linda J. Blumberg, Matthew Buettgens, and Robin Wang, "Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending," Urban Institute, March 2018, https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf.

77 Sungchul Park, Anirban Basu, Norma Coe, and Fahad Khalil, "Service-Level Selection: Strategic Risk Selection in Medicare Advantage in Response to Risk Adjustment," NBER Working Paper Series, National Bureau of Economic Research, November 2017, <http://www.nber.org/papers/w24038.pdf>.

78 "The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated," HHS Office of Inspector General, September 2015, <https://oig.hhs.gov/oei/reports/oei-02-13-00610.pdf>; "Chapter 9: Home Health Care Services," *Report to Congress: Medicare Payment Policy*, MedPAC, March 2017, http://medpac.gov/docs/default-source/reports/mar17_medpac_ch9.pdf?sfvrsn=0

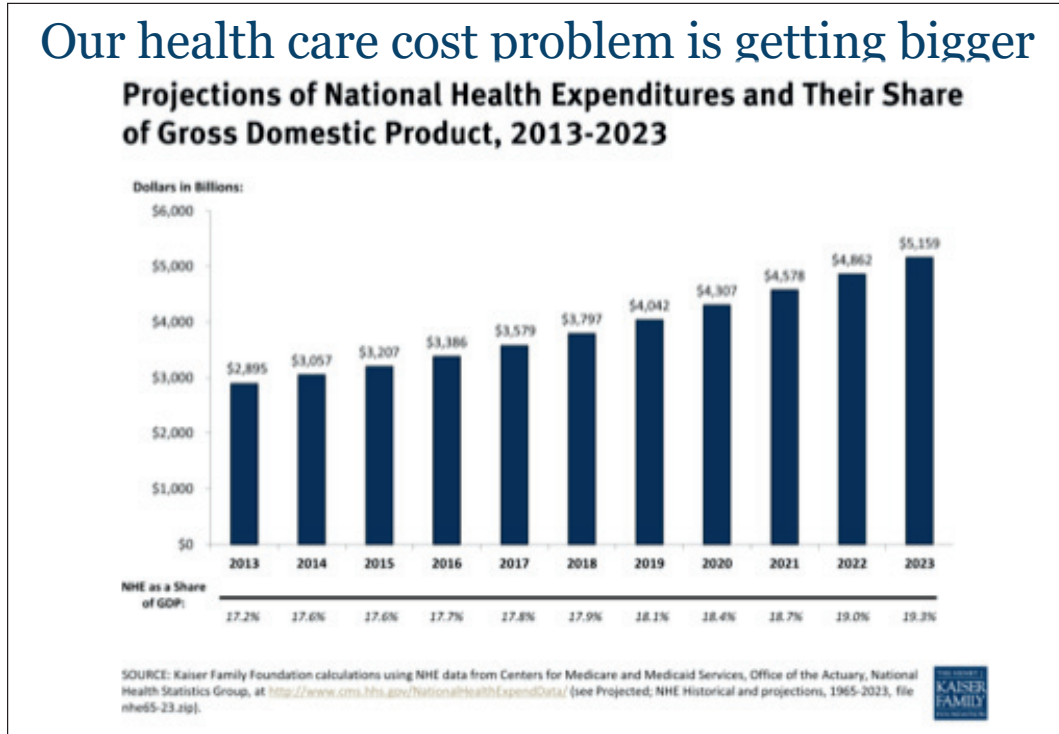


Figure 17: Slide from John Rother's presentation – multiple summits

A recent survey of health plans reported 21.8 million enrollees in HSA-HDHPs in 2017, a 9.2% increase over the previous year.⁷⁹ Proponents of HDHPs contend that they encourage shopping behavior among enrollees, and point to the reduction in overall employer spending when switching to HDHPs across their employee populations.

However, the landmark RAND health insurance experiment and subsequent research has shown that deductibles decrease the use of both necessary and unnecessary care.⁸⁰ Furthermore, some studies suggest that that the increase in deductibles may result in the postponement of needed care.⁸¹ This can include primary care or care for chronic illness – creating the potential for downstream costs associated with foregoing or delaying care. Efforts to improve diabetes outcomes, for example, encounter challenges if deductible or coinsurance deters needed medication use, regular physician visits, insulin, eye exams or foot exams.⁸²

Assuming the trend toward high deductibles continues, the health care system will likely face mounting affordability barriers to optimal delivery of care and allocation of resources.

79 "Health Savings Accounts and High Deductible Health Plans Grow as Valuable Financial Planning Tools," America's Health Insurance Plans, April 2018, <https://www.ahip.org/2017-survey-of-health-savings-accounts/>.

80 Joseph P. Newhouse, et. al., "The Effect of Coinsurance on the Health of Adults: Results from the Rand Health Insurance Experiment, RAND, December 1984. <https://www.rand.org/content/dam/rand/pubs/reports/2006/R3055.pdf>

81 Rachel Dolan, "High-Deductible Health Plans," Health Affairs Health Policy Brief, February, 4, 2016, https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf426401.

82 Julia Thornton Snider, et.al., "Impact of Type 2 Diabetes Medication Cost Sharing on Patient Outcomes and Health Plan Costs," *American Journal of Managed Care*, Vol. 22, No. 6, June 2016, <http://www.ajmc.com/journals/issue/2016/2016-vol22-n6/impact-of-type-2-diabetes-medication-cost-sharing-on-patient-outcomes-and-health-plan-costs>.

SECTION 3: Options

Having explored significant affordability trends and having identified six key cost drivers, it becomes possible to aggregate a portfolio of potential solutions tailored to address each. In this section, we describe possible remedies in the following six areas:

- Focus on Upstream, Non-Medical Interventions
- Combat Inefficient Care Delivery through Value-based Care
- Curb Misuse of Provider Market Power
- Remove Barriers to Transparency, Competition and Value in Prescription Drugs
- Curb Cherry-Picking and Risk Selection
- Align Cost-Sharing with Value

Focus on Upstream, Non-Medical Interventions

Given the centrality of chronic disease costs, rooted in non-medical (i.e. environmental, social, and behavioral) determinants of health, we begin with options intended to shift the focus of health policy beyond the four walls of the clinic or hospital.

Maintain the Federal Commitment to Public Health

The Prevention and Public Health Fund, one key mechanism for funding existing federal *prevention* initiatives, has been a matter of considerable political debate.⁸³ This fund was established in 2010 to insulate funding for major, strategic investments in prevention above and beyond ongoing discretionary program funding. Despite its importance, its funding has been reduced by Congress three separate times, eliminating more than a third of the original funds (See Figure 18⁸⁴). A portion of what funding it does provide has been redirected to the ongoing activities of the Centers for Disease Control and Prevention.

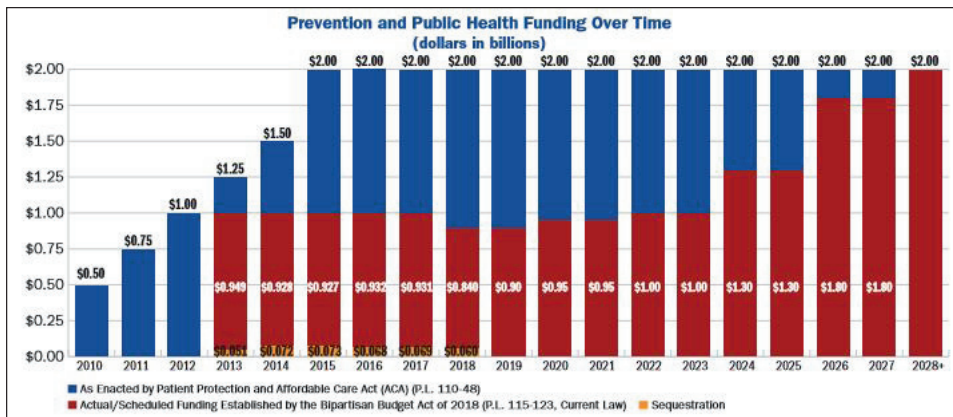


Figure 18

83 Robert Pear, "House to Vote on Child Health Care but Funding Will Remain in Limbo," New York Times, November 2, 2017, <https://www.nytimes.com/2017/11/02/us/politics/chip-childrens-health-insurance-program-congress.html>.

84 "Prevention and Public Health Fund Allocations (FY 2010-2025)" Trust for America's Health, <http://healthyamericans.org/health-issues/wp-content/uploads/2016/12/PPHF-CURES.png>

Fortunately, a policy alternative is available. The 21st Century Cures Act of 2016 included a dedicated funding mechanism for additional NIH research on *medical treatment*.⁸⁵ On a bipartisan basis, policy-makers should consider a similar consensus, permanent funding mechanism for *prevention* initiatives – accompanied by rigorous testing and evaluation to identify state-, local-, and privately-led prevention approaches that work.

Support Behavior Change

The United States must confront its burgeoning obesity epidemic if it is to move the needle on conditions like heart disease and diabetes. To do so, new policy frameworks are needed to support individual behavior change. Wherever cost-effective, intensive lifestyle change interventions should become as central to first line treatment of cardiovascular disease and endocrine disorders like diabetes as common medications like statins and insulin. Payers across the public sectors should utilize performance metrics and incentives to ensure this occurs. Spotlighting these interventions in clinical training could also help promote broader use of these interventions.

Simultaneously, the United States must grapple with the immediate and ongoing substance use disorder epidemic. The nation's policy response should support evidence-based substance abuse treatment and prevention programs – for both opioid use disorder and other substance abuse disorders. Additionally, that response should be geared toward growing an infrastructure and a workforce capable of responding to other current and future behavioral health challenges. The goal should be to help individuals struggling with addiction to receive the treatment needed to change their own future behavior.

To that end, swift action to lift barriers to investment in the full continuum of care by public programs, including medication-assisted treatment, outpatient services and, where appropriate, residential treatment, is needed. Furthermore, public programs and private purchasers alike can help break down siloes between physical and behavioral health by insisting that screening and referral to treatment becomes the standard of care wherever physical or behavioral health services are delivered. As plans and providers move towards managing the health of populations, their performance measurement systems should prioritize metrics related to substance use and mental health.

Furthermore, although tobacco use in the U.S. is now lower than other nations, smoking continues to generate \$170 billion in health care costs annually.⁸⁶ Recently proposed regulatory action to reduce nicotine content in cigarettes, if designed and implemented properly, has potential to strengthen the U.S. tobacco control regime. In addition, substantial increases to tobacco taxation and broader access to evidence-based cessation treatment can further drive down tobacco utilization.⁸⁷

Invest in Keeping Kids Healthy

Given the relationship between child health and future outcomes and health spending, a focus on children is a critical component of any broader effort to improve public health and support behavior change.

Moving forward, state and federal policymakers should prioritize research into the effectiveness, cost-effectiveness and scalability of a variety of interventions to reduce child exposure to Adverse Childhood Experiences. However, certain policy interventions are already known to be effective in improving child

85 Specifically, Section 1001 of 21st Century Cures Act specified that expenditures from a special NIH Innovation Account would not count toward statutory discretionary budget caps. See Amanda K. Sarata, "The 21st Century Cures Act (Division A of P.L. 114-255)," Congressional Research Service, December 23, 2016, <https://fas.org/sgp/crs/misc/R44720.pdf>.

86 Laura Bach, "Toll of Tobacco in the United States of America," Campaign for Tobacco-Free Kids, April 5, 2018, <https://www.tobaccofreekids.org/assets/factsheets/0072.pdf>.

87 "Raising the Excise Tax on Cigarettes: Effects on Health and the Federal Budget," Congressional Budget Office, June 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/O6-13-Smoking_Reduction.pdf

health: reducing childhood obesity, curbing child use of tobacco, alcohol and other drugs and assuring access to quality children’s coverage, particularly in Medicaid and CHIP.

Effective childhood obesity interventions should be deployed at scale, and state or federal resources should be made available to support that work. Policymakers should focus efforts to further delay the onset of smoking behaviors. Every effort should be made to discourage childhood exposure to opioids and other substances of abuse.

Finally, Medicaid remains a crucial enabler of health care access for children, particularly among vulnerable populations (See Figure 19 below). Ensuring access to care and evidence-based services for children in Medicaid should be a priority at both the federal and state levels.

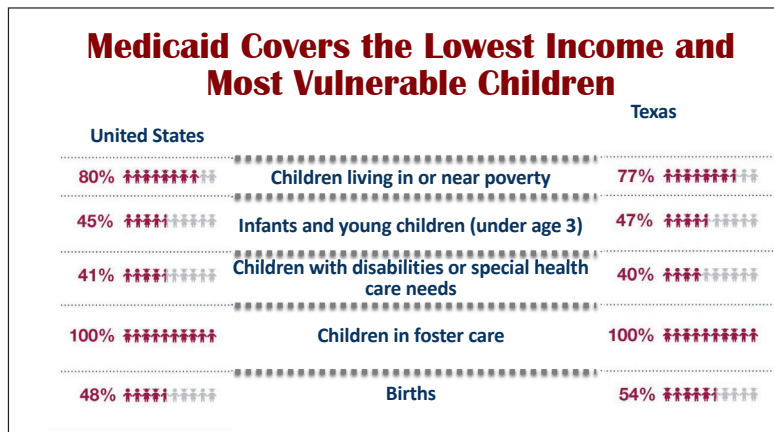


Figure 19: Slide from Tricia Brooks’ presentation – Texas Summit

Remove Barriers to Upstream Investments by the Health Care Sector

Notwithstanding the need for direct public investments in public health and community health, the resources and attention of the \$3.2 trillion health sector can and should be more deeply engaged in addressing non-medical determinants of health. Policymakers should ensure that upstream interventions face fewer barriers to investment and health care entities have adequate incentives to make them.

To begin, private payers and public programs alike should recognize FFS billing and reimbursement as a barrier to addressing both social and behavioral determinants of health. Broader use of capitated or partially capitated provider payment is necessary to permit providers to rededicate time and resources to ameliorating these determinants-- but it is not sufficient. Systems of performance measurement and accountability should incorporate measures that focus providers’ attention on outcomes, processes and referrals that extend beyond a clinical encounter in an office, clinic or hospital. Examples could include follow-up with other providers, adherence to treatment and medication plan and engagement with non-biomedical interventions like intensive lifestyle change or substance abuse treatment programs.

CMS and the HHS Office of Inspector General have the authority to establish a standard set or sets of compliance and benefit waivers to permit accountable care organizations, other alternative payment model entities and health plans to deploy upstream interventions. A standardized approach to issues like telehealth’s geographic and originating site regulations, Stark and Anti-Kickback Law restrictions, beneficiary incentives, and waivers of Medicare payment regulations would facilitate more efficient development and review of model proposals and encourage participation. Additionally, because Stark and Anti-Kickback cover provider or plan activity in the commercial market as well as public programs, it will be important to consider how any such waiver applies to activity outside of public programs.

Finally, as Medicaid continues to face scrutiny at the federal and state levels, policymakers should avoid categorical restrictions on the types of interventions supported by Medicaid dollars – particularly those non-medical or non-traditional approaches that address non-medical determinants of health. Whenever strong evidence supports an intervention -- as is the case with supportive housing, non-emergency medical transportation, in-home care for aging but not-yet-nursing home eligible enrollees, or residential substance abuse treatment -- state Medicaid programs should be free to pursue these particular innovations.

Combat Inefficient Care Delivery through Value-based Care

The discussion of cost-drivers above makes clear that the U.S. has not solved the problem of inefficiency in health care delivery. Fortunately, as repeatedly emphasized at NCHC’s Summits, an enormous opportunity exists to enhance the performance of the health care system – delivering better outcomes at a lower cost. Whatever else must be done with respect to broader issues of non-medical determinants, market dynamics and cost-sharing, seizing this opportunity remains the least that the health sector and policymakers ought to accomplish. Below, we outline options to address the wasteful subsidies, misaligned incentives, and workforce and infrastructure gaps identified above.

Reduce Incentives for Volume of Services

If the health care delivery system is to produce better value, it is first necessary to make volume-maximization a less lucrative business strategy for health care organizations. This is particularly important for the nation’s largest payer for health care services: traditional Medicare.

Fortunately, this is already beginning to happen. Ongoing hospital payment cuts, negotiated to finance the Affordable Care Act’s coverage expansion, are exerting pressure on those health systems that are invested in maximizing FFS volume (See Figure 20).

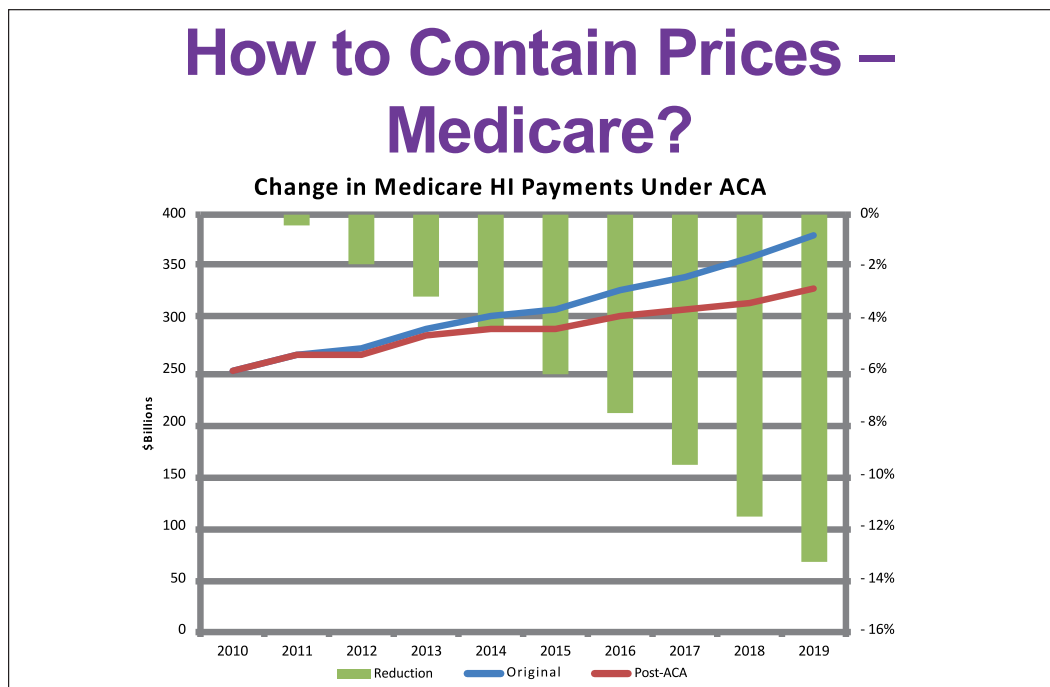


Figure 20: Slide from Sherry Glied’s presentation – Philadelphia Summit

MACRA's physician pay provisions are designed to accomplish a similar result with respect to clinician practices— albeit on a substantially gentler path.⁸⁸

While there is room for some flexibility in the pace and manner in which these provisions are implemented, this pressure on fee-for-service reimbursement is necessary, lest movement away from volume-based medicine stall. A business strategy based on maximizing volume of publicly reimbursed services, without regard for overall population health, must become increasingly less lucrative over time.

While leadership from the Medicare is indispensable, other payers and purchasers have an important role to play as well. They should make value of care the key factor in designing their provider networks, and pursue value-based contracts that align with population health models sponsored by public payers.

Offer More Upside for Delivery Innovation

It is also crucial that public payers, including Medicare and Medicaid, offer real upside financial opportunity to those plans and providers willing to reengineer their approach to care and payment. To the extent these organizations pursue innovative, cost-saving approaches to care delivery, success on their part can spur action from competitors who are still dependent on increasingly less lucrative volume-maximizing strategies.

Public programs should prioritize the continual evolution and expansion of those payment models that have proven to produce superior outcomes or lower costs when compared to status quo.

- From Accountable Care to Global Payments: ACOs have demonstrated improved cost performance when compared to unreformed FFS,⁸⁹ But the Medicare Shared Savings Program is far from perfect. Even as it pursues value-based aims, the Medicare Shared Savings Program uses the old FFS operating system. Participating physicians continue to bill for each Part B service, and hospitals bill for each admission, and following conclusion of the year the ACO may receive a bonus or penalty based on value. By contrast, global payment provides payment prospectively, (prior to care), for a substantial part of each covered patient. These prospective population-based payments, sometimes called capitated or per-member-per-month, are the gold standard of payment reform. Without the direct linkage between number of services or admissions, fee-for-service payment's incentives to deliver unneeded or costly care vanish. These global payment arrangements offer flexibility and resources that providers need to retool their operations to support upstream primary care and psychosocial interventions. Building on the Next Generation ACO program, traditional Medicare should ensure that advanced physician group and provider organizations have continued opportunities to assume full performance risk for a population.
- Health Management Organizations (HMOs): In some ways, HMOs are the original APM. Payments to plans in Medicare and Medicaid are typically prospective, globally-capitated payments, based on the size of the enrolled population. HMOs have the ability to build high quality networks and innovate highly advanced provider payment arrangements. Additionally, while retaining key beneficiary protections, HMOs can craft benefits and cost-sharing to steer beneficiaries to the most effective and efficient care providers, settings, and services. The results are generally positive. In Medicare Advantage for example, HMOs offered bids to provide the basic FFS benefit

88 For payment years 2017-2022, MACRA furnishes a five percent bonus for participation in Advanced APMs. Then in 2023, MACRA will provide a slightly higher pay increase for those in AAPMs (.75% vs .25%). At the same time, the statute exposes those who remain in MIPS to increasing penalties if their quality and resource use lag behind the average.

89 J. Michael McWilliams, "Changes in Medicare Shared Savings Program Savings from 2013-2014," *Journal of the American Medical Association*, Vol. 316 No. 16, October 25, 2016, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5083197/>.

package at 88% of FFS on average.⁹⁰ In fact, analysis from the Integrated Healthcare Association indicates that MA helped beneficiaries avoid \$3 billion in out-of-pocket costs in California alone.⁹¹ Ensuring that MA remains a strong and viable option for beneficiaries will enable both enrollees and the Medicare program continue to benefit.

- Primary Care Capitation: Building upon the primary care models now undergoing testing, CMS and private payers have an opportunity to establish transformative primary care models or programs that combine prospective, population-based payment for primary care services and shared savings based on total cost generated by the patient population. Services not included in the primary care population-based payment would be reimbursed separately. A recent Direct Provider Contracting (DPC) Request for Information from the CMS Innovation Center has expressed interest in testing such models.⁹²
- Coordinated Care Options for Dually Eligible Beneficiaries: Greater alignment between Medicare and Medicaid offers the prospect of improvement for those eligible for both programs. The federal government should support states' pursuit of a variety of strategies to achieve that improvement goal. Currently, states are pursuing integration through Medicaid health homes, single payment Medicare-Medicaid plans, Fully Integrated Dual-Eligible SNP products or the option to enroll in both a Medicare Advantage SNP and a MLTSS plan offered by the same sponsor. Federal policymakers can do more to help states develop a viable integration strategy that works for their circumstances. An extension of the enhanced matching funds for state Medicaid health homes beyond the current 24 months would bolster that integration strategy. Policymakers should also extend the ongoing Financial Alignment Initiative while they consider establishing a permanent three way contracting option that would continue to permit the delivering of full Medicare and Medicaid services in an aligned and integrated manner.

Strengthen Infrastructure for Value-Based Transformation

There are also certain crucial underpinnings that policymakers must get right for any of the approaches to delivery innovation described above to realize their potential.

- Improved Measure Alignment Across Payers: Effective measurement of quality is necessary to support improvement and to protect against stinting of care. Providers, physicians and other health professionals rightly object to duplicative, sometimes conflicting reporting requirements, but rather than retreating from robust performance measurement, the solution should be to harmonize measures across payers. Building on the work of the Core Measures Collaborative to identify core measure sets, Medicare should strengthen financial incentives to clinicians and providers who report on those particular metrics. Private payers and purchasers should make reporting on a simple and parsimonious set of core metrics a centerpiece of their contracts with providers.
- Strengthened Primary Care Workforce: Successful provider organizations will need strong, multi-professional care teams that are capable of reengineering care and driving that care upstream—not the imbalanced, specialty-heavy workforce which the United States trains today. Leveraging enormous taxpayer support for the health care workforce, policymakers can ensure that a focus on working in teams and in non-hospital settings is part of every professional discipline's education. The Teaching Health Center Graduate Medical Education program (THCGME) should be substantially expanded to new geographies and to additional primary care professions. Finally,

90 "Chapter 13-Report to Congress: Medicare Payment Policy," MedPAC, March 2018, http://medpac.gov/docs/default-source/reports/mar18_medpac_ch13_sec.pdf?sfvrsn=0

91 "California Regional Health Care Cost & Quality Atlas," Integrated Healthcare Association, <https://atlas.iha.org/>.

92 "Direct Provider Contracting Models - Request for Information" CMS, website, <https://innovation.cms.gov/initiatives/direct-provider-contracting/>.

expansion of team-based primary care practice opportunities for early-career professionals can also strengthen the workforce. To this end, increased investment in team-based practice opportunities are needed. Current programs include the nation's community health centers, the Veteran's Health Administration's primary and geriatric care initiatives, and Medicare's Independence at Home Practice Demonstration.

Curb Misuse of Market Power in Provider Markets:

The bulk of health care spending remains concentrated in hospital inpatient and outpatient services. Improving overall affordability will require a strategy to address the high hospital prices noted above – by policymakers and purchasers alike

The most obvious policy strategy to discouraging market abuses is to pursue classic trust-busting: prohibiting mergers of corporate entities that would harm consumers, or even breaking up market players with overweening power. There is an important role for these activities. However, given that most health care markets are already substantially concentrated, federal and state regulators should increase their attention to forestalling anti-competitive behavior by corporate entities in those concentrated environments. Federal regulators at the Federal Trade Commission could be directed and adequately resourced to police anti-competitive contracting like anti-steering and anti-tiering clauses. State policymakers should consider whether banning such practices is appropriate to their states' needs.

Purchasers, whether private employers, public agencies, or collectively bargained multiemployer health plans, also have an important role to play. Leading purchasers report large cost savings for certain services, through deployment tiered networks, centers of excellence, and in particular reference pricing initiatives like CalPERS' colonoscopy initiative.⁹³ (See Figure 21)

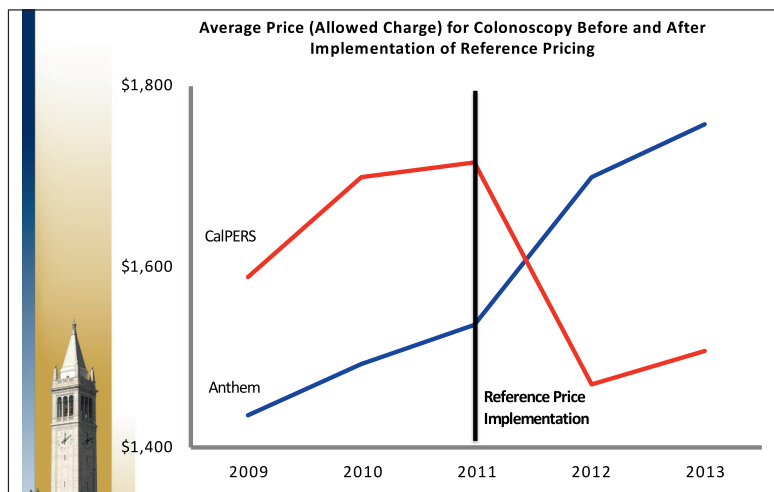


Figure 21: Slide from James Robinson's presentation – California Summit

Those purchasers with large employee or enrollee populations should explore whether similar approaches could increase their leverage with those health systems reliant on market power and excessive prices. Smaller employers, working through regional networks and business coalitions, may be able to achieve similar success with these and other innovative purchasing strategies.

93 James Robinson, "Reference Pricing as a California Purchaser Response to High and Rising Prices in Health Care," Berkeley Center for Health Technology, presentation to NCHC California Health Care Summit, September 12, 2017.

Bring Down Barriers to Transparency, Competition and Value in Prescription Drugs

To curb year-over-year inflation of both brand name and generic drugs, legislation that would have required manufacturers to justify price increases of more than 10% over a twelve month period was introduced in twenty-four state legislatures in 2018.⁹⁴ Initiatives and referenda have been advanced in other states to accomplish similar objectives.⁹⁵ These state efforts may help put the spotlight on rising prices and are generally constructive.

However, given that the market for prescription drugs is national, the most impactful solutions are more likely to be found at a national level.

Ensuring more transparent access to information about the value of various drugs is key. Lifting the statutory ban on consideration of cost by the Patient Centered Outcomes Research Institute would be a step in this direction. Additionally, the FDA could be given new authorities, including the ability to share cost information with payers in advance of launch and the ability to require the same sort of comparison to other therapies that drug companies routinely submit to European drug regulators. Registries can be required and their findings made public to inform valuation of therapies after introduction.

Once a new drug is approved, with this new information, both public and private payers have a critical role to play. They can insist that drugs that make only marginal clinical improvements will not be priced the same as breakthrough remedies.

At the same time, policymakers will have to curtail gaming of today's patent and drug approval systems. A Commonwealth Fund report has called for the establishment of a new 'clinically equivalent standard' at FDA that would permit generic competition whenever minor, clinically insignificant changes are made to a product.⁹⁶ Legislation has been introduced for several successive Congresses to ban pay-for delay arrangements- without enactment. Additionally, despite remarkably broad bipartisan support, proposals which requires making REMS-restricted samples available to generics, have yet to advance. Twelve-year exclusivity periods for biologic medications, far in excess of those available in other nations, persist, along with a broad use of orphan drug act authorities. If markets are to have a chance at improving prescription drug affordability, policymakers will have to address these barriers to cost-saving competition.

For their part, private payers and health plans should insist that pharmacy benefit management contracts promote the most affordable, highest-value medications, and that generic and biosimilar options are made available wherever possible at a lower cost than the brands.

For certain generics, small markets may make competition unrewarding for generic manufacturers, leading to withdrawals from the market. Since competitive forces are no longer effective with limited-source generic drugs, other measures are appropriate and needed to support affordable generic alternatives. These can include expedited approval of an additional generic competitor, if there is an interested company or authorized importation of that specific drug from Canada, Japan, or the European Union.

Ultimately, it may be that even stronger public action is required to counter the market failures driving up prescription drug prices. Outright price-setting on public and private prices could have unintended

94 "State Legislative Action on Pharmaceutical Prices," National Academy of State Health Policy, updated May 18, 2018, <https://nashp.org/state-legislative-action-on-pharmaceutical-prices>.

95 "State Legislative Action on Pharmaceutical Prices," National Academy of State Health Policy, updated May 18, 2018.

96 Henry Waxman, Bill Corr, Kristi Martin, and Sophia Duong, "What Commissioner Gottlieb's FDA Is Doing to Lower Prescription Drug Prices and Steps Congress Can Take to Help," Commonwealth Fund, issue brief, April 2018, http://www.commonwealthfund.org/-/media/files/publications/issue-brief/2018/apr/waxman_gottlieb_plan_fda_ib.pdf.

consequences. But several presenters at the NCHC regional summits explored leveraging the purchasing power of Medicare to ratchet down prices in Medicare Part B and Part D, while preserving the freedom of private sector plans and employers to negotiate their own pricing arrangements. Presenters noted the potential to lower costs for beneficiaries and for the Medicare program.

Establishing such a policy, particularly in Part D, would not be a simple undertaking. Enabling Medicare to negotiate prices effectively would require reliance on an evidence-based formulary, such as that used by the Veteran’s Administration. This strategy would also require authorizing Medicare to utilize a range of pharmacy benefit management tools and benefit design tools, like reference pricing or other forms of differential cost-sharing to promote utilization of the medications that are best supported by the evidence. One estimate concluded that utilizing the VA formulary in Medicare Part D could save as much as \$20 billion a year.⁹⁷ It may be useful to fund research to accurately estimate the potential savings and other possible benefits of such a policy.

Curb Cherry-Picking and Risk Selection

As noted in the discussion of cost drivers above, individual health insurance markets face substantial risk selection both within comprehensive, ACA-compliant insurance markets and between those markets and recently expanded short-term and association health plan markets. Further destabilization of the individual markets is an urgent policy challenge. Even in the most stable state market, California, consumers face premium increases of between 36 and 94 percent over the next three years (See Figure 22 below).

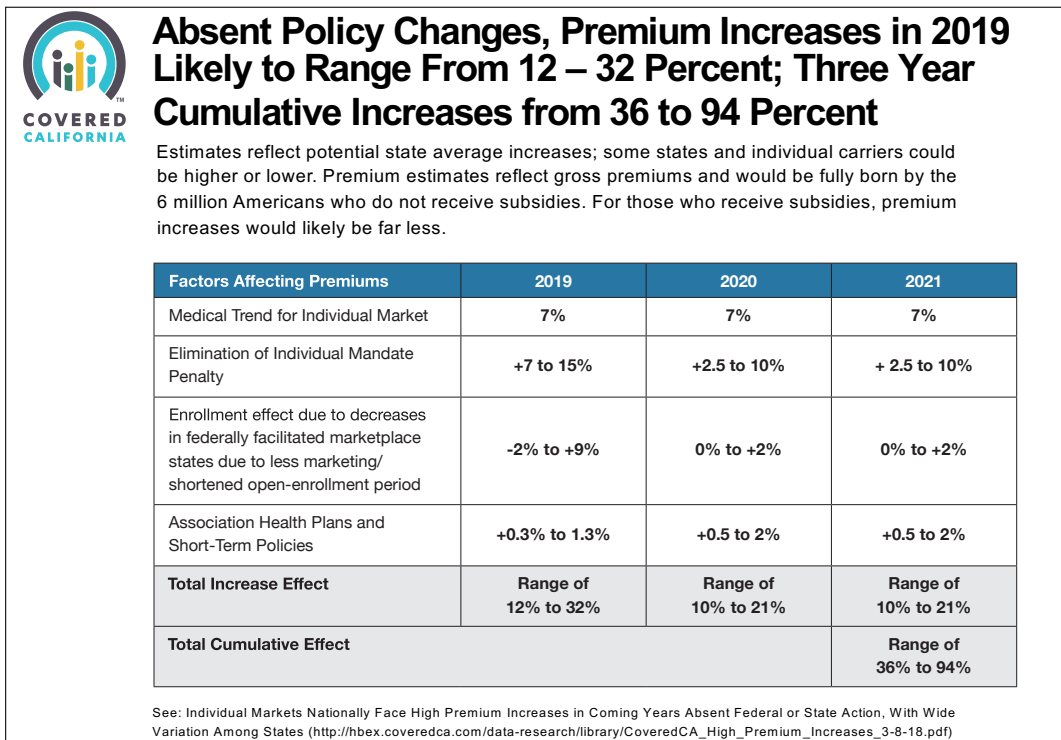


Figure 22: Slide from Peter Lee’s presentation – Southern California Summit


97 Alfred B. Engelberg, “The VA Pharmacy Benefit Manager should Take Over the Operation of Medicare Part D,” *Health Affairs Blog*, April 20, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180413.855463/full/>

Policymakers should avoid further legislative or regulatory steps to expand less comprehensive AHPs and STLDI plans at the national level or to otherwise destabilize the individual market. Then taking into account the 2019 plan year experience, federal policymakers could consider steps to roll back the destabilizing effect they may have.

In the meantime, additional federal policy changes to strengthen individual insurance markets overall are desirable. For example, federal policymakers could establish broad, federally-funded reinsurance, and repeal recently adopted regulations which allow states to reduce risk adjustment payments to exchange plans.⁹⁸

Federal policymakers should also consider supporting state efforts to automatically enroll certain subsidy eligible residents in low-or no-cost coverage options. These and other steps to broaden enrollment in individually purchased insurance could stabilize markets and restrain cost increases.

For their part, states also have policy levers available to promote more stable individual markets over the short term. States, using their own regulatory and statutory authorities, should consider supporting increased enrollment outreach, limiting the sale of short-term health plans in their states, requiring individual market coverage to be sold on the exchange, and/or establishing new penalties under state law for failure to maintain creditable coverage. (Figure 23 details these and other policy options)



Federal and State Actions that Could Promote Stability Policy Actions That Could Promote Stability for 2019 and Beyond

- **Reinsurance:** State-based and/or national reinsurance programs, could have a dramatic impact on premiums and carrier participation in 2019.
- **Directly Fund Cost-Sharing Reduction (CSR) Subsidies:** Funding CSRs would **not** directly reduce premiums but would provide needed stability for health plans and reduce federal spending.
- **Increased Subsidies:** Increasing the financial assistance that is available to consumers would help more Americans afford coverage and increase the overall health of the consumer pools.
- **Increased Marketing and Outreach:** Increasing spending on targeting marketing promotes enrollment among healthier individuals and benefits federal taxpayers — who benefit from reduced per-person Advanced Premium Tax Credits — and those who do not receive subsidies and face lower premium increases.
- **State-Based Penalties for Non-Coverage:** States could adopt state-based penalties to promote enrollment.
- **State Regulations on Association Health Plans or Short-Term, Limited-Duration Plans:** States could adopt regulations that limit carriers from offering plans that do not provide comprehensive coverage or protect consumers with pre-existing conditions, which could harm the risk pool in the individual market.
- **Auto-Enrollment:** State or federal policies could promote automatic enrollment of eligible individuals, such as for those who lose employer-based coverage, earn too much for Medicaid or “age out” of coverage eligibility from parents plans

Figure 23: Slide from Peter Lee’s presentation – Southern California Summit

98 “HHS Notice of Benefit and Payment Parameters for 2019 Fact Sheet,” Center for Medicare and Medicaid Services, April 9, 2018, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-09.html>

However, even as they seek to address the pressing need for stabilization of the individual market, policymakers will have to recognize that Medicare has an outsize impact on the overall health care system and take steps to address cherry-picking in Medicare risk adjustment and payment policies.

Policymakers should improve the predictive accuracy of the Medicare Advantage's risk adjustment system. Specifically, insofar as the current system under-predicts the costs associated with LTSS users, regulators could develop an adjustment that accounts for functional status, LTSS use or both. Such a policy change also could improve risk adjustment among Medicare ACOs which rely on payment benchmarks tied to MA's risk adjustment system. Similarly, effective risk adjustment is essential if the global and primary care capitation models described above are to serve beneficiaries with significant medical needs and avoid cherry-picking.

With respect to reimbursement for post-acute care in Medicare, MedPAC has repeatedly recommended changes to existing skilled nursing and home health payment systems to reduce incentives for cherry-picking healthier patients. In 2018, progress appears to be underway. Section 50101 of the Bipartisan Budget Act of 2018 enacted home health payment reforms that, if properly implemented, could address some of these issues. CMS has proposed payment changes to skilled nursing facilities that would better cover the costs associated with medically complex patients.⁹⁹

While moving forward with these changes in the short term, policymakers should also seek to implement another MedPAC recommendation, the establishment of a single post-acute care prospective payment system (PAC PPS). This policy would base PAC payment amounts on beneficiaries' functional and medical needs, rather than on the specific setting in which they receive services (e.g. long-term care hospital, intermediate rehabilitation facility, skilled nursing facilities). Properly designed and implemented, a PAC PPS could reduce the current incentive for higher-cost provider types to seek out healthier, lower-cost patients who could be more efficiently treated in other settings.

Align Cost-Sharing with Value

If the other policy options discussed here are to produce optimal results, the transformation of health care payment and delivery will need to be accompanied with changes in the structure of today's benefits and cost-sharing designs. As noted repeatedly at the NCHC Summits and in the discussion of trends and cost drivers above, patients are bearing more of the cost of care- even in the relatively stable and comparatively generous employer-sponsored plans upon which the majority of Americans rely. (See Figure 24)

⁹⁹ "Medicare proposes fiscal year 2019 payment and policy changes for skilled nursing facilities," Centers for Medicare and Medicaid Services, fact sheet, April 27, 2018, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-27-4.html>

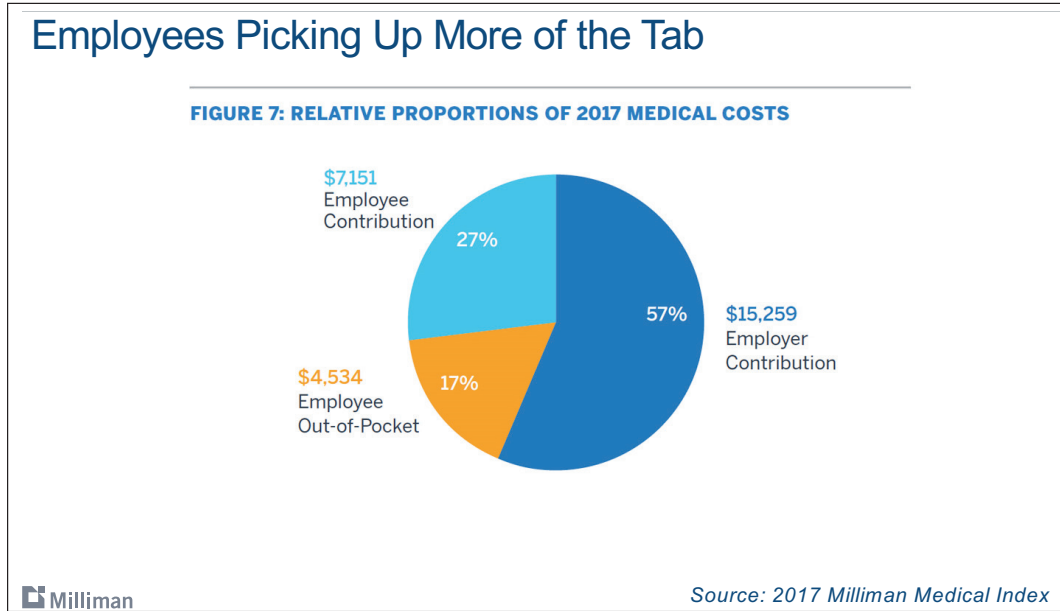


Figure 24: Slide from Scott Weltz' Presentation – Georgia Summit

The presence of high deductibles appears to be the reality of insurance for tens of millions of Americans today. This presents real barriers to care, but a return to zero-deductible, zero cost-sharing for all desired care is simply unlikely. Fortunately, broader application of value-based insurance designs can mitigate these undesirable impacts.

Today, US Department of Treasury's guidance governing High-Deductible Health Plans associated with an HSA denies plan sponsors the flexibility to cover chronic care, even high-value services, until the entire deductible is met.¹⁰⁰ Policymakers should promote deductible exclusions to mitigate the impact of high cost-sharing on the delivery of the highest value services. Specifically, payers could be given the legal and regulatory flexibility to exclude ongoing care for chronic conditions from their deductible. Additionally, plan sponsors could be given the flexibility to exclude a modest number of ambulatory primary care visits from the deductible of high-deductible plans. Together, these improvements would begin to align today's benefit structures with ongoing payment reform efforts.

In the broader marketplace, however, private plans, employers and state and local governments should pursue other benefit design strategies that balance the need to alleviate cost-barriers to needed primary care services without inducing unnecessary utilization. For example, the State of California's state health insurance marketplace, Covered California, has made coverage of ambulatory care visits a standard for all participating plans.¹⁰¹ The largest public health care purchaser in the United States, CalPERS, has implemented a benefit structure in its broad-network coverage, that reduces the size of the deductible and copays if an enrollee chooses a primary care provider.¹⁰² Careful evaluation of these experiences should be used to inform future policymaking in this area.

100 "IRS Notice 2004-23"; Internal Revenue Service, <https://www.irs.gov/pub/irs-drop/n-04-23.pdf>.

101 Peter V. Lee, "The Individual Market: Prospects for Stability, the Policy Whirlwind and the Roller Coaster Continues," presentation for NCHC's Southern California Health Care Summit, March 28, 2018, <https://nchc.org/wp-content/uploads/2018/04/Peter-Lee-USC-Schaeffer-Ctr-3.28.18.pdf>.

102 Kathy Donneson, "Strategies and Barriers to Affordability," presentation for NCHC's Southern California Health Care Summit, March 28, 2018.

Conclusion:

This report has described a daunting set of health care affordability challenges for families, employers and public institutions. We have identified a complex set of cost drivers: unaddressed social, behavioral and environmental determinants, health care delivery inefficiency, provider, drug and insurance market failures, along with unhelpful cost barriers to high-value care. Given the breadth of both the challenges and drivers, it is only to be expected that simplistic, one-shot solutions will fall far short of the mark.

Drawing on the literature and the summits, therefore we have outlined a portfolio of options that we believe are appropriate to the scale of the challenges while tailored to the complexity of the cost drivers. It is our hope that the summits, this report, and these options can help engender a conversation that will move us closer to a multi-faceted, national response to our health care affordability crisis.

APPENDIX: Agendas for Regional Summits



Working Together for an Affordable Future

AGENDA

Chicago Health Care Summit: Strategies for Improving the Affordability of Care and Coverage

July 25, 2017, 9:00 am – 12:00 pm CST

Presentations & Discussion

John Rother
*President & CEO,
National Coalition on Health Care*

Trish Riley
*Executive Director,
National Academy for State Health Policy*

Joseph Minarik
*Senior Vice President and Director of Research,
Committee for Economic Development*

Joseph Antos
*Wilson H. Taylor Scholar in Health Care and Retirement Policy,
American Enterprise Institute*

Gerard Anderson
*Professor of Health Policy and Management,
Johns Hopkins University Bloomberg School of Public Health;
Director, Johns Hopkins Center for Hospital Finance & Management*

Panel of Experts

Larry Boress
*President and CEO,
Midwest Business Group on Health*

Michael Koetting
*Former Deputy Director,
Illinois Department of Health & Family Services*

Donald Lurye, MD
*President,
Illinois Academy of Family Physicians*

Jason Parrott
*Manager of Healthcare Strategy and Policy,
The Boeing Company*

Fred D. Rachman, MD
*CEO,
Alliance Chicago*

Thomas Sondergeld
*Vice President, Global Benefits and Mobility,
Walgreens Boots Alliance*

This event is made possible by a generous grant from the Gordon and Betty Moore Foundation.



**California Health Care Summit:
Strategies for Improving the Affordability of Care and Coverage**

The Citizen Hotel, Sacramento, CA

September 12, 2017

11:00 am – 3:15 pm PST

11 – 11:05 am: Welcoming Remarks

- **Liana Bailey-Crimmins**, *Chief Health Director*, California Public Employee Retirement System (CalPERS)
- **Congressman Ami Bera**, *CA 7th District*

11:05 am – 12:30 pm: Presentations and Discussion

- **John Rother**, *President & CEO*, National Coalition on Health Care
- **Suzanne Delbanco**, *Executive Director*, Catalyst for Payment Reform
- **James Robinson**, *Leonard D. Schaeffer Endowed Chair in Health Economics and Policy*, University of California, Berkeley; *Director*, Berkeley Center for Health Technology
- **Geoffrey Joyce**, *Director of Health Policy*, Leonard D. Schaeffer Center; *Associate Professor and Chair of the Department of Pharmaceutical and Health Economics*, University of Southern California

12:30 – 1:25 pm: Luncheon and Keynote Speaker

Diana Dooley, *Secretary*, California Health and Human Services Agency

1:25 – 2:20 pm: Provider Perspectives

- Chaired by **Jack Lewin**, *Chairman*, National Coalition on Health Care; *Principal and Founder*, Lewin and Associates, LLC; *former President and CEO*, California Medical Association
- **Dustin Corcoran**, *CEO*, California Medical Association
- **Donald Crane**, *CEO*, CAPG, The Voice of Accountable Physician Groups
- **Kenneth Kizer**, *Director*, Institute for Population Health Improvement; *Distinguished Professor*, University of California, Davis, School of Medicine
- **Janet Liang**, *President of the Northern California Region*, Kaiser Permanente

2:20 – 3:15 pm: Purchaser Perspectives

- Chaired by **Kathleen Donneson**, *Chief of Health Plan Administration Division*, CalPERS
- **Phil Jackson**, *CEO of Health Plan Products*, Sutter Health Plus
- **David Lansky**, *Chief Executive Officer*, Pacific Business Group on Health
- **Doug McKeever**, *Chief Deputy Executive Director*, Covered California
- **John Prince**, *CEO*, OptumRx at UnitedHealth Group

Closing Remarks

John Rother and Liana Bailey-Crimmins

The Coalition worked in close partnership with the California Public Employee Retirement System to plan this summit. We thank the superb CalPERS team.

This summit was made possible by a generous grant from the Gordon and Betty Moore Foundation. We are grateful for their ongoing guidance, counsel, and support.



**New York Health Care Summit
Strategies for Improving the Affordability of Care and Coverage**

Carnegie Hall, Weill Music Room

November 2, 2017

9:00 a.m.-12:00 p.m.

AGENDA

Welcoming Remarks

Jack Lewin

Chairman, National Coalition on Health Care; Principal and Founder, Lewin and Associates, LLC

Presentations & Discussion

John Rother

President & CEO,
National Coalition on Health Care

Sara Collins

Vice President, Health Care Coverage and Access,
The Commonwealth Fund

Bunny Ellerin

President, New York City Health Business Leaders; Director, Healthcare and Pharmaceutical Management Program, Columbia Business School

Neil Goldfarb

President and CEO, Greater Philadelphia Business Coalition on Health;
Chair, National Alliance of Healthcare Purchasing Coalitions

Joseph Minarik

Senior Vice President and Director of Research, Committee for
Economic Development

Keynote Presentation:

Ezekiel Emanuel

Vice Provost for Global Initiatives, Diane v.S. Levy and Robert M
Levy University Professor, and Chair of the Department of Medical
Ethics and Health Policy, University of Pennsylvania.

Author, [Prescription for the Future: The Twelve Transformational
Practices of Highly Effective Medical Organizations](#)

This event is made possible by a generous grant from the Gordon and Betty Moore Foundation.



**Pennsylvania Health Care Summit:
Strategies for Improving the Affordability of Care and Coverage**

Union League of Philadelphia
November 15, 2017 | 9:00 am - 12:15 pm

Welcome/Presentation	John Rother <i>President & CEO,</i> National Coalition on Health Care
Presentations & Discussion	Lawrence Ward <i>Vice Chairman for Clinical Practice and Quality and Associate Professor of Medicine,</i> Department of Medicine, Thomas Jefferson University Fiona Greig <i>Director of Consumer Research, JPMorgan Chase Institute</i> Allyson Schwartz <i>President and CEO, Better Medicare Alliance;</i> <i>former Member of Congress</i> Len Nichols <i>Director, Center for Health Policy Research and Ethics,</i> <i>and Professor of Health Policy, George Mason University</i>
Keynote	Sherry Glied <i>Dean and Professor, Robert F. Wagner Graduate School of Public Service,</i> New York University
Expert Panel Discussion	Neil Goldfarb (Chairman) <i>President and CEO, Greater Philadelphia Business Coalition on Health;</i> <i>Chair, National Alliance of Healthcare Purchasing Coalitions</i> Stewart Beltz <i>Vice President, Health and Wellness,</i> The Board of Pensions of the Presbyterian Church (U.S.A.) Marsha Greene-Jones <i>Deputy Director of Human Resources, City of Philadelphia</i> Tara O'Neill Hayes <i>Deputy Director of Health Care Policy, American Action Forum</i> Lynn Quincy <i>Director, Healthcare Value Hub, ALTARUM</i>

This event is made possible by a generous grant from the Gordon and Betty Moore Foundation.

 **@NC_HC #PAHealthSummit**



Georgia Health Care Summit Strategies for Improving the Affordability of Care and Coverage

The Carter Center, Cyprus Room
December 13, 2017 | 9:00 am - 12:30 pm

Welcoming Remarks

Jack Lewin, *Chairman*, National Coalition on Health Care; *Principal and Founder*, Lewin and Associates, LLC

Opening Remarks

Eve Byrd, *Director*, Mental Health Program, The Carter Center

Formal Presentations

- **John Rother**, *President & CEO*, National Coalition on Health Care
- **Kenneth Thorpe**, *Robert W. Woodruff Professor and Chair*, Department of Health Policy and Management, Rollins School of Public Health, Emory University
- **Karen Minyard**, *Director of the Georgia Health Policy Center and Research Professor*, Department of Public Management and Policy, Georgia State University
- **Von Nguyen**, *Acting Associate Director for Policy*, Centers for Disease Control and Prevention (CDC)
- **Scott Weltz**, *Principal and Consulting Actuary*, Milliman

Break

Formal Presentations (continued)

- **Jennifer Tolbert**, *Director of State Health Reform*, The Henry J. Kaiser Family Foundation
- **Peter Fise**, *Senior Policy Analyst*, Bipartisan Policy Center

Expert Panel Discussion

- **Jack Lewin** (Chair)
- **Laura Colbert**, *Executive Director*, Georgians for a Healthy Future
- **Loy Cowart**, *President*, Georgia Academy of Family Physicians
- **Kimberlee Johns**, *Director*, Employee Benefits, Mohawk Industries
- **Paula Sanford**, *Public Service and Outreach Faculty Member*, Carl Vinson Institute of Government, University of Georgia

This event is made possible by a generous grant from the Gordon and Betty Moore Foundation.



**Southern California Health Care Summit:
Strategies for Improving the Affordability of High Quality Care and Coverage**
Wednesday, March 28 | 9:00 am to 12:00 pm

#USHealthSummit

OPENING REMARKS: 9-9:15 am

Liana Bailey-Crimmins, *Chief Health Director*, California Public Employees Retirement System - @CalPERS

John Rother, *President & CEO*, National Coalition on Health Care - @NC_HC

PRESENTATIONS & DISCUSSION: 9:15-10:30 am

Dana Goldman, *Director*, Leonard D Schaeffer Center for Health Policy & Economics - @SchaefferCenter

Katherine Hayes, *Director of Health Policy*, Bipartisan Policy Center - @BPC_Bipartisan

Peter V. Lee, *Executive Director*, Covered California - @CoveredCA

Amy Nguyen Howell, *Chief Medical Officer*, America's Physician Groups - @AmerPhysGrps

BREAK: 10:30-10:40 am

EXPERT PANEL DISCUSSION: 10:40 am-12:00 pm

Moderator: Jack Lewin, *Chairman*, National Coalition on Health Care - @NC_HC

Kathleen Donneson, *Chief of Health Plan Administration Division*, CalPERS - @CalPERS

Susan Hogeland, *Executive Vice President*, California Academy of Family Physicians - @cafp_familydocs

Gerald Kominski, *Director*, UCLA Center for Health Policy Research - @UCLAchpr

Geoffrey Joyce, *Director of Health Policy*, Leonard D. Schaeffer Center, USC - @SchaefferCenter

Tam Ma, *Legal and Policy Director*, Health Access California - @healthaccess

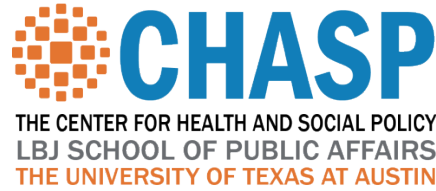
Jeffrey Rideout, *CEO*, Integrated Healthcare Association - @IHAConvene

CLOSING REMARKS

Liana Bailey-Crimmins, *Chief Health Director*, California Public Employees Retirement System - @CalPERS

John Rother, *President & CEO*, National Coalition on Health Care - @NC_HC

This event is made possible by a generous grant from the Gordon and Betty Moore Foundation.



Texas Health Care Summit: Health Today, Health Care Tomorrow
Thursday, March 29 | 9 am to 12:30 pm
Bass Lecture Hall at The LBJ School of Public Affairs

OPENING REMARKS: 9:00-9:05 am

Cynthia Osborne – *Director, Center for Health and Social Policy, LBJ School of Public Affairs, University of Texas at Austin - @chasp_lbj*

John Rother – *President and CEO, National Coalition on Health Care - @NC_HC*

KEYNOTE: 9:05-9:30 am

Charles Smith – *Executive Commissioner, Texas Health and Human Services Commission - @TexasHHSC*

PRESENTATIONS AND DISCUSSION: 9:40-10:55 am

John Rother

Cynthia Osborne

Georges Benjamin – *Executive Director, American Public Health Association - @PublicHealth*

Mark Hayward – *Professor of Sociology, Centennial Commission Professor in the Liberal Arts, University of Texas at Austin - @LiberalArtsUT*

Tricia Brooks – *Senior Fellow, Center for Children and Families, Georgetown University McCourt School of Public Policy - @McCourtSchool*

BREAK: 10:55-11:00 am

LEADERSHIP PERSPECTIVES: 11:00 am-12:00 pm

Jack Lewin (Moderator) – *Chairman, National Coalition on Health Care - @NC_HC*

Frederick P. Cerise – *Chief Executive Officer, Parkland Memorial Hospital - @Parkland*

Susan Distefano – *CEO, Children’s Memorial Hermann Hospital - @memorialhermann*

Jamie Dudensing – *CEO, Texas Association of Health Plans - @txhealthplans*

Ben Raimer – *President-Elect, Texas Pediatric Society*

KEYNOTE: 12:00-12:25 pm

Clay Johnston – *Inaugural Dean, Dell Medical School, University of Texas at Austin - @DellMedSchool*

CLOSING REMARKS

John Rother

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