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Cracking the Code on Health Care Costs

A Report by the State Health Care Cost Containment Commission



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JANUARY 2014

Preface

The United States has done little to rein in the cost of health care over the past few decades. During this period, rising costs have had a major negative impact on individuals and families, and the growth of Medicaid and Medicare has been a main driver of federal deficits. Similarly, at the state level, Medicaid growth has limited public investments in elementary, secondary, and higher education and infrastructure. Unfortunately, health spending is projected to continue to grow over the next two decades as the population ages and health care access expands due to the Patient Protection and Affordable Care Act.

Recently, the national debate has revolved around two different health care approaches. First, because the government does little to restrain health care spending, it cuts other portions of the budget to pay for it. Second, the government reduces benefits in Medicare and Medicaid. Neither approach is sustainable in the long run: The first will lead to dramatic reductions in long-term economic growth, and the second is not politically feasible.

The State Health Care Cost Containment Commission was created to provide a practical alternative strategy that can provide higher-quality care and reduce the rate of cost increases, primarily by changing the health care delivery system. States need to lead this effort, because they have most of the policy levers and because reform must be tailored to the unique culture and health care market in each state. The federal government can support the states, but the leadership needs to start with governors, legislators, and other health care stakeholders and be adopted at the grass-roots level, where health care is delivered by individual clinics, hospitals, and physicians across the state.

It is my hope that this report helps light a prairie fire on health care cost control that starts with two or three states in this year's legislative sessions, and then spreads to 10 to 15 more states next year. Once started, I am sure that states will learn from each other, much as they did on clean air, welfare reform, and education reform.

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University of Virginia
Charlottesville, Virginia
January 8, 2014

Faulkner House, home to the Miller Center, University of Virginia

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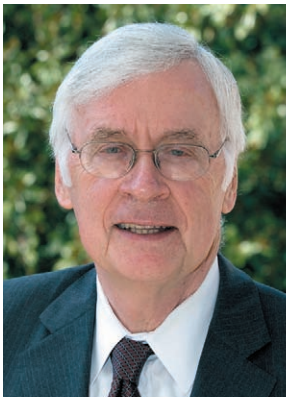
Director and CEO, Miller Center, University of Virginia
Governor of Virginia (1986–1990)



This report is a major signpost in the long-running debate about the future of health care in the United States.

The Miller Center appreciated the opportunity to host the work of the State Health Care Cost Containment Commission during 2012 and 2013. This work is consistent with the Center's mission to serve as a central gathering place for nonpartisan public discussion since our founding almost 40 years ago. Other recent public policy issues addressed by the Miller Center include presidential war powers, federal transportation policy, and the challenges facing America's middle class.

Health care access, quality, and costs have been at the center of the nation's public policy challenges for much of the past two decades and are likely to remain at the forefront for the foreseeable future. The next few years are particularly important, because significant changes will occur in the health care system as the federal and state governments implement the Patient Protection and Affordable Care Act. Many health care analysts have stated that this act has created universal access, and now the nation needs to focus on quality enhancements and cost restraints.

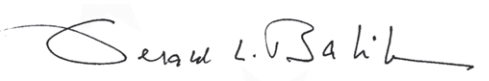
Unlike some policy issues where we know what to do but lack the political will, health care reform is in its infancy; thus, we must go through a period of accelerated state experimentation to determine what really works. As U.S. Supreme Court Justice William Brandeis indicated in 1932, states are the laboratories of democracy. The report of the Commission provides states with a blueprint to follow during this period of experimentation. Much like states have led in clean air, welfare reform, and education reform, they are the likely level of government to lead the transformation of the health care system, because they have most of the policy levers.

The Miller Center is extremely appreciative of the leadership of its two co-chairs, Mike Leavitt, former governor of Utah and secretary of the U.S. Department of Health and Human Services, and Bill Ritter former governor of Colorado. The Center is also indebted to all the other members of the Commission. This is an outstanding group of professionals who represent different health care perspectives but are united in their vision that the system can be changed to one of higher quality and lower cost.

The Commission had numerous conference calls and met three times in our Washington, D.C., office to develop consensus on all the critical components of the

final report. The combination of former government and private-sector leaders led to rich and robust discussions and an amazing amount of consensus from the first to the last convening.

Much of the national discussion about health care reform in recent years has focused on the federal government—federal legislation, federal agencies, federal funding. Yet the role of state governments in the success of federal health care reform is critical. During such a significant time of change in our health care system, I hope this report stimulates action this year by many state governors and legislators.



Letter from the Co-Chairs

Hons. Mike Leavitt and Bill Ritter Jr.

State governments have a unique opportunity to transform the current health care system into one that provides higher-quality care at lower costs. The State Health Care Cost Containment Commission was created to identify how states might use their authorities and policy levers to guide this transformation.

This report was written for state health care leaders across the 50 states, including governors, their cabinet members (particularly Medicaid directors, human resources directors, and insurance commissioners), and state legislators. In addition to the elected and appointed political leadership in the states, it is our hope that all health care stakeholders, particularly business leaders and citizens, will read the report, because all are integral to achieving consensus on ways to transform the health care system in each state.

The recommendations in this report were arrived at by the State Health Care Cost Containment Commission, which represents key sectors of the health care community—insurance plans, hospitals, and physician provider groups. It also includes representatives from the main groups that purchase health care—Medicaid and Medicare clients, private individuals, and consumer advocates. The members of the Commission are optimistic that the time for change has come and that we have the knowledge to drive and institute that change.

We and the other Commission members unanimously approve this report.

The Honorable Mike Leavitt, *Co-Chair*
Former Governor of Utah and Secretary, U.S. Department of Health and Human Services

The Honorable Bill Ritter Jr., *Co-Chair*
Former Governor of Colorado

Andrew Dreyfus, *President and CEO*
Blue Cross Blue Shield of Massachusetts

Simon Stevens, *Executive Vice President*
UnitedHealth Group

Glenn D. Steele Jr., M.D., *President and CEO*
Geisinger Health System

George C. Halvorson, *Former Chairman and CEO*
Kaiser Permanente

Jay Cohen, M.D., *Senior Vice President, External Affairs, Optum*

Joan Henneberry, *Principal, Health Management Associates, and Former Executive Director, Colorado Department of Health Care Policy and Financing*

Robert D. Reischauer, *Medicare Trustee and Former Director, Congressional Budget Office*

Lloyd Dean, *President/CEO*
Dignity Health

Rob Restuccia, *Executive Director*
Community Catalyst

Michael L. Davis, S*enior Vice President, Global Human Resources*
General Mills

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John Thomasian was the lead researcher and writer of the report. He is to be congratulated for his unique ability to understand the interaction of the health care system and the policy levers of state government. Becky Fleischauer of Navigator Communications provided key assistance in drafting external communications and advising on the overall communication strategy. Tess Moore, with her great humor, was indispensable in her role as organizer and liaison between the project staff and the commissioners.

The advice of Tim Garson, the former dean of the University of Virginia Medical School, was invaluable throughout the entire project. In addition, the following reviewers provided valuable insights and comments: Paul Ginsberg, Jon Kingsdale, Stuart Butler, Eric Patashnik, Darin Gordon, Alan Weil, and Bill Scanlon.

Also, special thanks go to several of the staff who worked closely with commissioners, including Janet Shikles with Glenn Steele of Geisinger, Sara Iselin with Andrew Dreyfus of Blue Cross Blue Shield of Massachusetts, Wade Rose with Lloyd Dean of Dignity Health, and Michael Miller with Rob Restuccia of Community Catalyst.

I also wish to thank the staff at the Miller Center—Amber Lautigar Reichert, Juliana Bush, Kristy Schantz, and Kim Curtis—for all their assistance throughout the study.

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Executive Summary

The cost of health care in the United States has reached a tipping point as spending by individuals, governments, and businesses has grown steadily for over five decades. In 1960, health care costs per individual averaged $147; by 2011, this figure had reached $8,860. This is more than twice the average spent by all other developed countries in the Organization for Economic Cooperation and Development (OECD). Although there has been a recent lull in the growth of health care spending, it is likely temporary. If current practices in health care delivery and compensation remain the same, projected costs will reach $14,103 per person by 2021.

Despite our massive investment in health care, Americans are far less healthy than our peers elsewhere in the developed world. U.S. health quality is average or below other countries on several important measures, including life expectancy, infant mortality, obesity, diabetes, chronic lung illnesses, and heart disease. Moreover, although some of the most advanced medicine in the world is practiced in the United States, surgical errors, medical mistakes, and poorly coordinated care are not uncommon.

If we do not act to curb the growth in health care spending, it will continue to take a toll on our individual and national prosperity. Higher costs will limit growth in family real incomes; add to the nation's debt; crowd out important investments in education, infrastructure, research, and other areas; and place United States–based businesses that compete globally at a disadvantage. The nation cannot afford to devote an ever-rising share of the economy to a health care system that is inefficient, costly, and less than superior in quality.

Past trends do not necessarily dictate the future, however. The nation's health care system is now entering a unique period of change. Over the next decade, millions more Americans will become enrolled in health insurance plans, which will encourage the creation and reorganization of health care delivery systems to accommodate the newly insured. Health care purchasers and many providers are becoming more cost conscious. Urged by health care payers, which include federal and state governments, many provider organizations and hospitals are forming partnerships to improve the efficiency and quality of care. This is a positive trend that may lead to more cost-effective, higher-quality care in the future, but this transformation is slow and not universal. Moreover, other trends such as the consolidation of hospitals and provider groups to gain market leverage may counter the positive aspects of this transformation.

Nevertheless, the opportunity exists to transform how health care is delivered. The Commission believes that governors, along with key members of state cabinets and legislatures, are in the best position to lead that change.

The goal is straightforward but ambitious: Replace the nation's reliance on fragmented, fee-for-service care with comprehensive, coordinated care using payment models that hold organizations accountable for cost control and quality gains. Achieving this will take time. There is inertia in the current system and few incentives for changing it. However, the states are in a strong position to achieve meaningful reforms and create the needed incentives with the support of payers, providers, insurers, and consumers. As the nation's "laboratories

of democracy," states can serve as a proving ground for new approaches that raise the efficiency and value of health care.

What Drives Health Care Costs in the United States?

Health care costs are high in the United States because of several interrelated factors:

- **Physician, facility, and drug costs are high.** Average unit costs for physicians, facilities, and drugs in the United States are almost universally the highest in the world. Even the lowest U.S. costs often exceed those in all other countries.
- **Americans use a higher proportion of expensive medicine.** Even though Americans visit doctors less frequently, enter hospitals less, and have shorter hospitals stays than other OECD countries, they make up for it by using more expensive medical technologies and costly procedures. For example, although an average of 46.3 magnetic resonance imaging diagnostics are conducted per 1,000 individuals throughout the OECD, the U.S. rate is 97.7—more than double the OECD average.
- **Care is fragmented and uncoordinated.** U.S. health care for the most part is fragmented, with minimal clinical information transferred across care settings and infrequent consultation among providers treating the same patient. This contributes to unnecessary and redundant services, errors and hospitalizations, delays in treatment, patient dissatisfaction, and excessive expense.
- **Consumers do not weigh costs when making health care decisions.** Other than insurance premiums and out-of-pocket expenses, consumers pay little attention to the cost of care. In fact, numerous studies have shown that consumers generally equate high-cost treatment with high-quality care and will choose the most expensive treatment among options that are equal in quality but vary substantially in cost.
- **The traditional fee-for-service payment model promotes fragmentation and higher spending.** The most common payment model in the United States is fee for service, which compensates physicians for each service they deliver. For many experts, fee for service encourages providers to maximize the amount and cost of the services they deliver.
- **Administrative expenses are high.** Billing and insurance-related activities for health care in the United States are the most expensive in the world because of (1) the complicated, numerous, and unique billing procedures employed by different insurance plans and (2) a fragmented system in which each provider organization maintains its own administrative process and personnel.
- **Unhealthy lifestyle choices and behaviors add to health burdens.** Unhealthy behaviors in the United States help cause chronic illnesses, such as heart disease, stroke, cancer, diabetes, and arthritis. These ailments cause approximately 70 percent of all deaths in the United States and afflict one in every two adults, raising the cost of health care treatment

nationwide. Most believe that a large share of these conditions is avoidable.

- **End-of-life care in the United States is expensive.** Americans consume a significant share of their lifetime medical costs in their last year of their lives, often because of aggressive treatments and repeated hospitalizations that are unnecessary, unwanted, and inappropriate.
- **Provider consolidation and market power.** Provider consolidation among and between hospitals and physician groups is rampant throughout the health care industry, with a great deal of it focused on increasing market share. Although such consolidation can create organizations that are more efficient and provide higher-quality care, it can sometimes create health systems that dominate markets, placing upward pressure on the price of services.

Role of the States in Health Care

States play a major role in influencing health care and its delivery system. Using numerous policy levers, they can influence how the system is organized and how it operates. They can motivate it to pursue greater efficiency and enhanced quality and discourage market behavior that results in wastefulness and unreasonable price increases. Notable policy levers include:

- **Government-sponsored health care programs such as Medicaid or Children's Health Insurance Program (CHIP), state employee health benefits, and health insurance exchanges.** States are a major market participant in health care, directing how dollars are spent for Medicaid/CHIP and for state (and often local) employee health benefits. States can use these investments to influence the health care system toward organizational structures that are accountable for cost management and quality improvement. States can also influence the type of plans offered in their insurance exchange. Exchanges can encourage the participation of plans that focus on quality, price, and value. States can steer consumers to higher-value plans by assigning ratings or displaying the plans more prominently on the exchange Web site.
- **State laws and authorities governing insurance, scope of practice, provider rates, and medical malpractice.** States possess several traditional authorities and powers that can influence health care delivery and the cost of care. They can use insurance premium rate review to identify provider costs that appear unreasonable. They can eliminate state-mandated benefits that do not reflect evidence-based medicine and contractual rules between insurers and providers that hinder more efficient care. Scope-of-practice rules can be changed to allow nonphysician providers to practice independently and at their full level of competency. Medical malpractice policies can be altered in an attempt to lower defensive medicine costs. And, as they have done in the past, states can elect to regulate the prices that providers charge for specific services.

- **State laws promoting consumer choice through price and quality information and ensuring market competition through antitrust authority.** States can require plans and providers to report information on prices and quality to encourage consumers to select high-quality, cost-efficient care. States also have their own antitrust authority, which can be used to discourage provider consolidation that leads to noncompetitive behavior.
- **The authority to enact policies in schools and invest in public health initiatives designed to improve population health.** In an effort to create a healthier population, states can adopt policies to promote healthy communities, improve the physical well-being of children, and encourage exercise and better nutrition, including establishing school nutrition and physical education standards, providing financial support to expand local bicycle and walking paths, increasing community access to healthy foods by supporting farmers' markets, and providing loans and grants to grocery stores that locate in underserved communities.
- **The power of governors, working with cabinet members and legislators, to engage stakeholders in major public policy issues and create a process for change.** States can play a major role in engaging stakeholders and creating a framework to solve public policy issues. Developing a consensus among all stakeholders to modify norms, such as health care payment models, often can be as effective as new laws or regulations. In health care, governors and legislatures can create temporary or permanent commissions that bring together stakeholders to address rising health care costs. States can also create supporting institutions to collect, analyze, and track information on health care costs and quality over time.

Fixing the Problem

The members of the State Health Care Cost Commission offer the following seven recommendations, which are explained in greater detail in the body of this report.

Recommendation 1: Create an Alliance of Stakeholders to Transform the Health Care System (Pages 67–68)

To move toward a more cost-effective health care system, government must form an alliance with purchasers, the medical community, and other stakeholders to create a consensus and commitment for change. Changing how health care is delivered will require a comprehensive approach that can take many years. The state can lead this transition and provide institutional support, but it cannot succeed without the long-term commitment of all stakeholders, including payers, consumers, and providers.

A state alliance for transforming health care delivery can take several forms, largely influenced by the culture and key players in the state. Some states may be able to effect change through temporary commissions, advisory groups, and volunteer efforts. Others

may require more permanent and formal institutional structures and enabling legislation or executive orders. Whatever approach the state chooses, it must be prepared to lead and support certain critical actions, including establishing goals for improving quality, curbing spending, and monitoring progress.

Recommendation 2: Define and Collect Data to Create a Profile of Health Care in the State (Pages 68–71)

Working with their stakeholder alliance, states should establish a common definition of health care spending, identify quality-tracking measures, create a process for collecting cost and quality data, and conduct an initial analysis of where health care spending is concentrated and outside national norms. The state should also conduct an inventory of the health care delivery infrastructure.

Key actions include:

- **Define health care spending.** States should create a common measure of health care spending that allows identification of a baseline and permits year-to-year tracking of spending growth. The Commission recommends that each state use a formula that calculates the total cost of medical care divided by the population in the state (i.e., per-capita spending).
- **Collect detailed data on health spending throughout the state.** The state must establish a means of collecting detailed information on medical spending throughout the state. This information should be used to establish an initial baseline; analyze changes and trends on a yearly basis; and provide information on costs among providers, services, and regions.
- **Conduct an initial comparative analysis and determine subcomponents of health care spending.** The state should calculate baselines costs for various subcomponents of health care to determine current spending patterns in the state. The state should compare state baselines to national averages, costs in different geographic regions, and costs across different providers and plans.
- **Define and collect data on the quality of health care delivery.** The state should identify a set of quality measures that all health care organizations in the state consistently report.
- **Collect data on key population health statistics and factors that affect population health.** Most states have already established a process to gather, analyze, and report trends in key population health statistics, such as death, cancer, heart disease, obesity, diabetes, alcohol and tobacco use, infant mortality, and immunization status. Such data are often broken down by race, gender, and geographic location. Collecting and tracking such data should help the state, providers, and other institutions set priorities for improving population health.
- **Inventory the health care infrastructure, including providers and plans.** The state should work with its alliance to conduct an inventory of the state's health care

infrastructure. The inventory should identify the type and number of health care insurers and provider organizations in the state and the process through which care is delivered and compensated.

Recommendation 3: Establish Statewide Baselines and Goals for Health Care Spending, Quality, and Other Measures as Appropriate (Pages 71–73)

The state and its alliance should establish appropriate targets for cost growth and quality improvements in the health care system. They should collect timely and accurate data annually and report to the public and policymakers on progress in meeting goals. Such annual reports should be used to inform the development of policies to assist in meeting the goals.

Key actions include:

- **Adopt annual spending benchmarks for the next 5 years.** The state should establish specific goals or limits on the annual percentage increase of per-capita total health care expenditures over at least the next 5 years. The Commission recommends that the state set the target as some fraction of state economic growth, such as a percentage of gross state product.
- **Adopt annual benchmark goals on quality for the next 5 years.** To ensure that cost management does not come at the expense of health care quality, the state should establish annual benchmarks for quality improvement and overall quality performance for each measure providers report.
- **Adopt benchmark goals for key population statistics.** The state should set long-term goals for tracking improvements in population health. This information can be used to focus public health policies and draw attention to care delivery needs.
- **Conduct an annual review of spending and quality and report the results.** Each year, the state should review the most up-to-date spending and quality data.

Recommendation 4: Use Existing Health Care Spending Programs to Accelerate the Trend Toward Coordinated, Risk-Based Care (Pages 73–78)

States should use health spending programs they administer or oversee to support formation of high-performing coordinated care organizations that accept risk-based, global payments. Programs that states can use for leverage include Medicaid, the state employee health program (which can be combined with local government employees for increased influence), and health insurance exchanges.

Key actions include:

- **Create a state definition of coordinated, risk-based care.** States should create a standard definition of what constitutes a high-performing coordinated care organization that manages costs and promotes quality using risk-based payments. Such a definition would

establish goals for all health care organizations in the state and allow payers to identify plans that deliver the best care and value.

- **Transition Medicaid for children and adults toward patient-centered, high-performing care.** States have been steadily increasing their use of Medicaid managed care to cover a large share of their population, particularly children and adults. Seventy-four percent of all Medicaid enrollees are already in some form of managed care, and a large portion of these plans already uses risk-based payments. After states create a definition for *high-performing, risk-based coordinated care*, they should begin urging their Medicaid managed care plans to upgrade to meet the state definition.
- **Work with plans and providers to create the capacity to provide coordinated, risk-based care to the disabled and dual-eligible population.** To better manage costs and improve outcomes, states have been encouraging delivery systems to build the capacity to serve this population through coordinated care using risk-based payments. This transition has begun in some states and should continue.
- **Negotiate contracts to cover state employees through coordinated, risk-based care.** As in the Medicaid program, states should negotiate contracts with health care providers and insurers to provide coordinated, risk-based care to serve state employees. To increase their market influence, states should work with local governments and create common benefit plans for state and local employees. Doing so would accentuate the purchasing power of both governments.
- **Use health insurance exchanges to encourage the offering and selection of coordinated, risk-based care plans.** Exchanges can be used to encourage consumers to choose certain types of plans. For example, exchanges can display cost and quality information, including out-of-pocket costs, to help customers compare plan value. Exchanges can also encourage plans to incorporate payment reforms such as global budgeting to encourage greater cost management.

Recommendation 5: Encourage Consumer Selection of High-Value Care Based on Cost and Quality Data, and Promote Market Competition (Pages 78–80)

States can help ensure that consumers are given the information they need to consider cost in their health care decisions and that adequate competition exists in the health care marketplace. States can make the cost and quality of health care services more transparent by reporting such information on a statewide basis and requiring plans to publish such information for their members. Antitrust authority can be used proactively and reactively to ensure that consolidation of health care providers achieves greater efficiency, not market leverage over prices.

Key actions include:

- **Adopt policies that require plans to provide consumer-friendly and timely data on price and quality.** Consumers need accurate, timely, and comparative information on

cost and quality within and across plans to make more informed choices on health treatment options. To reach this level of detail, states should require each health plan to report quality ratings and cost of different procedures, including out-of-pocket expenses, for all hospitals and providers within the plan.

- **Use state action and antitrust powers to promote beneficial consolidation and limit the exercise of market power.** States can use their antitrust powers to encourage consolidation as a means of reorganizing the system into more efficient care, or they can attempt to block it if it leads to market leverage in setting prices.

Recommendation 6: Reform Health Care Regulations to Promote System Efficiency (Pages 81–82)

State health care regulations affecting insurance, scope of practice, and medical malpractice can influence health care costs. The state should review these policies to determine whether they promote cost efficiency or present obstacles to expanding the availability of risk-based, coordinated care.

Key actions include:

- **Review and streamline state requirements and mandates.** States should review their current list of state regulations and benefit mandates enforced by insurance departments, including contractual rules between plans and providers, rules on provider access, and essential benefits. The review should examine whether the rules and mandates unnecessarily add to the cost of health services or inhibit the expansion of risk-based, coordinated care.
- **Review state malpractice laws.** For more than a decade, states have been taking actions to reduce the costs of medical malpractice. States should review their medical malpractice policies and modify those that have substantial direct and indirect costs to the system.
- **Revise scope-of-practice policies to allow providers to use the full range of their competencies.** The drive toward greater coordination in care delivery and a growing population covered by insurance will strain the supply of skilled providers in many areas, particularly those involved in primary care. To help meet this demand, states should support policies that allow skilled nonphysicians at all levels to practice at the full range of their competencies, including the ability to bill independently. States should also consider granting reciprocity to providers licensed in other states as practiced by states in the Nursing Licensure Compact.

Recommendation 7: Help Promote Better Population Health and Personal Responsibility in Health Care (Pages 83–86)

States can use education and the bully pulpit, wellness programs for state employees, and public health initiatives to promote population health and encourage individuals to take more personal responsibility for their health care decisions. In addition, states can make

it easier for individuals to make informed end-of-life treatment choices that reflect their personal wishes.

Key actions include:

- **Educate citizens about the importance of lifestyle choices.** An important role for states is to educate the public on the value of maintaining a healthy lifestyle. Governors in particular can play a key role in these efforts, and most states today have a gubernatorial initiative designed to promote a "healthier state." Most of these actions require minimal resources and often rely on volunteer efforts.
- **Assist schools and community organizations to adopt policies that promote healthy lifestyles.** In addition to education, states can adopt more aggressive policies that promote healthy lifestyles in schools and communities. These policies often require some state resources and either legislation or executive orders to implement.
- **Work with state employees to make better lifestyle decisions.** Typically the largest single employer in the state, state governments can use their employee benefit plans to encourage and promote healthier lifestyles among a large portion of the workforce.
- **Educate citizens on the value of creating instructions for end-of-life care.** States can assist in ensuring that patients are given the opportunity to make informed end-of-life decisions, including the option to access to palliative and hospice care.

The Federal Role

The federal government has a role to play in helping states transform the health care delivery system. A major positive step is its effort to encourage the use of accountable care organizations (ACOs) in Medicare. ACOs are helping move the Medicare system away from fee for service to integrated and coordinated care, with financial incentives to manage costs and improve quality.

In addition, the report highlights several areas in which federal regulations or laws could be changed to strengthen states in their quest for higher-quality, cost-effective care. These run the spectrum from providing states with timely Medicare and Medicaid claims data to supporting more research and demonstration initiatives to help states test new cost control policies.

Ensuring Long-Run Progress

Bringing down the growth rate in health care spending will take time and vigilance. The goal in each state should be to lower the growth rate of the cost of care per individual to a level that approximates the state's economic growth rate. Accomplishing this will require

a long and sustained commitment by all major health care stakeholders in the state. The strategies proposed in this report largely rely on transparency, purchasing power, payer and provider cooperation, persuasion, and "soft" regulatory pressure to spur the transition to more efficient, quality care. Over time, however, the state may need to consider additional corrective action for some high-cost outliers. States have many levers at their disposal to encourage compliance with state goals.

The time for state action is now. The health care system is already moving toward payment reforms and more coordinated care in response to pressure from purchasers and, to some extent, incentives in the Patient Protection and Affordable Care Act. However, many of these changes are slow and tentative. States can accelerate change and create additional incentives for large-scale reforms.

Controlling the rise in health care spending offers substantial future benefits to individuals, families, businesses, and governments. Health care costs already consume 18 percent of the nation's output, as measured by the gross domestic product. Even small reductions in the growth rate will improve wage growth; business competitiveness; and the opportunity for governments to invest in programs that spur prosperity, such as education, infrastructure, and research. But failing to act will have consequences. Without systemic reforms, health care expenses will continue to consume an ever-larger share of the nation's wealth, eventually threatening its economic future.

Commission Report

Introduction

This report describes how state leadership—particularly gubernatorial leadership—can transform the current health care system into one that is more coordinated, patient centered, and affordable by using payment models that promote cost management and quality improvement. This transformation must occur at the grass-roots level within individual health care systems, hospitals, clinics, and medical practices. It must be propelled by those who pay for health care—both public and private payers—and by those who use it—the citizens in the cities, small towns, and rural communities throughout the nation. And it must be led by state governments—governments that are close to the people and known for creating innovative solutions to tough policy issues.

Health care today in the United States is fragmented, inefficient, and unnecessarily costly; it also fails to deliver high-quality results consistently. States have several motives for tackling these problems. First, rising health costs for governments, businesses, and consumers erode a state's competitive position and business climate. By moderating the growth of health care spending, states can attract business and jobs. Second, health care spending affects real incomes. If a state can hold down health care cost increases, the wages of workers in the state will grow at a faster pace, and per-capita incomes will rise. Finally, states are major purchasers of health care, covering their workers, retirees, and Medicaid recipients. Such costs have begun to crowd out other investments essential for a strong economy and vibrant society. If states hope to adequately finance education, infrastructure, and other programs that promote prosperity, they must curb the rise in health care spending.

Many policymakers instinctively turn to the federal government to find solutions, but the government's ability to restrain health care costs and improve care delivery is limited. The federal government can reduce reliance on inefficient and expensive fee-for-service care in Medicare by encouraging new organizational models that reward coordination, quality, and cost management. Through its oversight role, it can support states as they create higher-value care in the Medicaid program. Ultimately, however, transforming how medical services are delivered must involve more than the organizations that serve the Medicare and Medicaid population. All health care providers and organizations must embrace the same goals of improving cost management and outcomes. In this regard, states

possess certain advantages over the federal government in influencing how health care delivery is organized and compensated.

States can use numerous policy levers to spur system change. One of the most important levers is the ability of governors to engage citizens and stakeholders on issues of major public importance. The convening power of the governor, although not listed in any state constitution, is extremely powerful in helping obtain a consensus and commitment to take action. This is essential to changing the health care system, because states must gain the commitment of all purchasers, the cooperation of the medical community, and the support of consumers.

After the state establishes a plan for action with purchasers and other stakeholders, it can use the purchasing power of the state Medicaid and employee health programs to create and support health organizations that commit to meeting cost and quality expectations. Health insurance exchanges that sell coverage to individuals and small businesses can encourage the creation of and enrollment in high-quality, cost-effective health plans and coordinated care delivery systems. In addition, states can modify their malpractice laws, scope of practice policies, and insurance rules to remove barriers to cost-effective care. States can drive improved cost management by reviewing insurance rate increases, tracking differences in provider costs throughout the state, and publishing information on the cost and quality of different health systems. Finally, states can inform consumers about the price and quality of treatment options available to them so they can choose the best value.

Governors and state policymakers understand their local health care market and the payers, providers, and stakeholders that comprise it. This knowledge is critical for building a consensus for change and identifying solutions that reflect the state's culture and health care infrastructure. States have long pioneered reforms in areas such as education, welfare policy, clean air laws, and health coverage. Although transforming the health care system is a major undertaking, it is within the scope of these previous efforts. As Justice Brandeis said in his dissent to a 1932 U.S. Supreme Court decision, "It is one of the happy incidents of our federal system that a courageous state may, if its citizens choose, serve as a laboratory, and try novel social and economic experiments with no risk to the rest of the nation."

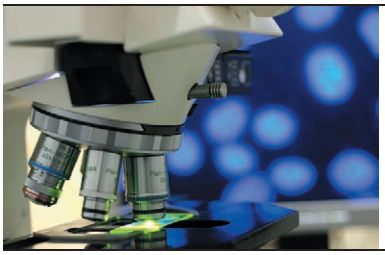
Finally, it is important to stress that the cost of health care in the United States is near a tipping point. Additional increases over the next decade will have significant economic repercussions for citizens, businesses, and all levels of government. For this reason, there is an urgency to begin bending the cost curve now. Changing the health care system into one that is more accountable for managing costs and improving outcomes will take many years—perhaps a decade or more. Because health care is largely a local service, deeply entwined with state and regional economies, states are in the best position to start the process and enable this transformation.

About This Report

The report contains five chapters. Chapter 1 describes issues with the current American health care system and the factors that make it the most expensive in the world. The issues will be familiar to those who study health policy, but they are important to enumerate, because they are the key obstacles preventing higher-value care.

Chapter 2 describes how the health care system is evolving and the type of changes that are expected over the next decade and longer. These changes are marked by expanded insurance coverage and a nascent trend toward new organizations for delivering care that are focused on quality improvements and cost management. States must consider and exploit these trends when implementing any strategy designed to curb the rise in health care spending.

Chapter 3 describes the large number of policy levers states possess that affect the health care market and organization of services. Chapter 4 presents the Commission's recommendations on how states can use their policy levers to facilitate system change. Finally, Chapter 5 describes policies that the federal government can adopt to support and amplify state actions.



1. Unsustainable Spending and Mixed Quality

America spends more than any other country on health care, and the cost per person is growing. The mounting expense is limiting wage growth; adding to the nation's debt; crowding out important public investments in areas such as education, infrastructure, and research; and placing United States–based businesses that compete globally at a disadvantage. At the same time, Americans are not getting a big return on their investment. U.S. health quality is average or below other countries on several important measures, including life expectancy, infant mortality, diabetes, and heart disease. Moreover, surgical and medical errors are not uncommon. As a result, health care purchasers of all types—including government—are searching for ways to stem the rise in health care spending and improve health care value.

Many factors contribute to America's high health care spending, including costly physician and facility fees, overuse of high-priced services, unhealthy lifestyles and poor population health, delivery systems that lack care coordination, high administrative expenses, payment policies that both reflect and bolster fragmentation of care, and provider consolidation that can lead to market dominance. All conspire to push costs higher.

This chapter briefly reviews trends in health care spending; the effect of rising prices on consumers, government, and businesses; and some of the reasons U.S. health care is so expensive. Determining where we are, how we got here, and where we may be going are important first steps in crafting policies that improve health care quality and value.

Trends in Spending and Quality

National expenditures for health care have grown steadily for over five decades. In 1960, the nation spent a total of $27.4 billion for health care, or $147 per person. At that time, health care dollars accounted for only 5.2 percent of the nation's gross domestic product (GDP). By 2011, health expenditures reached $2.7 trillion, or $8,860 per person, and their share of GDP stood at 17.9 percent (see Figure 2).[1]

This upward drift is expected to continue. Despite modest growth rates between 3.8 percent and 3.9 percent from 2009 through 2011—still above inflation—health care spending

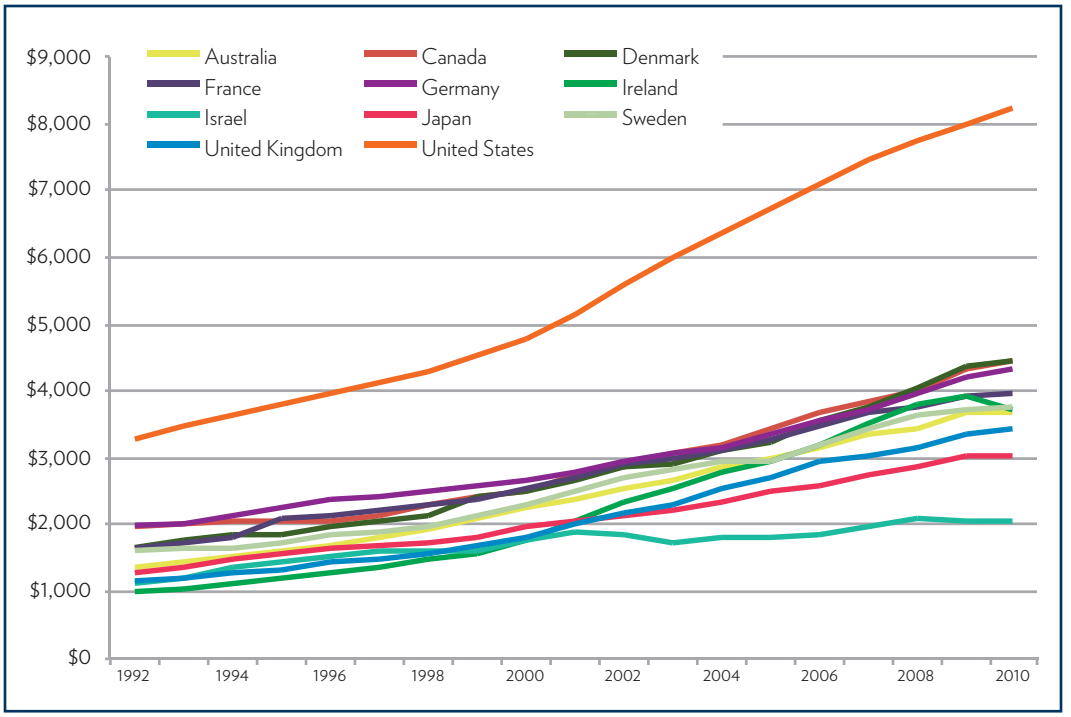


Figure 1: Health Care Costs Per Capita, Select Countries

is expected to accelerate once again as the economy strengthens and the Patient Protection and Affordable Care Act (ACA) is implemented. By 2021, projected payments should reach 19.6 percent of GDP, or just under $14,103 per person—62 percent higher than in 2011.

Although rising health care costs are not unique to the United States, the rate of increase and the scale of spending sets us apart from other industrialized countries (see Figure 1). In 2010 (or nearest year), the average per-capita cost for health care across the Organization for Economic Cooperation and Development (OECD)—excluding the United States—was $3,265. This is below the U.S. rate by more than half (60 percent), and the gap is widening.

Quality of Care

Superior population health does not match the high levels of U.S. spending. A recent report from the National Research Council found that, although the *United States is among the wealthiest nations in the world, it is far from the healthiest.*[2]

The average lifespan of Americans is below that of 17 other industrialized countries and has been falling behind for more than three decades (partly because of high rates of infant mortality). In fact, Americans as a group fare worse in several measures, including low birth weight, adolescent pregnancy and sexually transmitted infections, human immunodeficiency virus and acquired immune deficiency syndrome (AIDS), obesity and diabetes, heart disease, chronic lung disease, and disability.

Although some subpar health trends can be attributed to the lack of health coverage

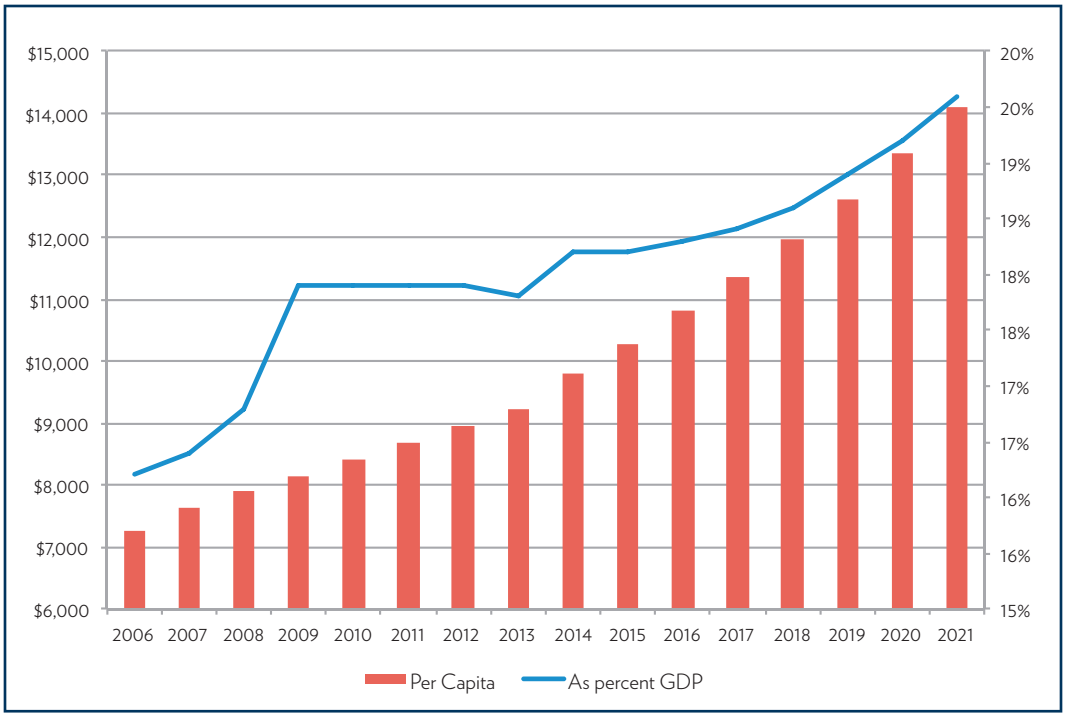


Figure 2: National Health Expenditures

and medical care for some populations, research suggests that even advantaged Americans who have access to care are in poorer health than their peers in other countries.[3] Moreover, the care they receive is often not better—and is frequently worse—than their foreign counterparts. One study found that the United States had the second-highest death rate among 19 OECD countries from conditions that could have been prevented or treated successfully.[4] Surgical and medical errors also appear high in the United States, as do mistakes involving medications and patients receiving incorrect test results.[5]

The Impact of Rising Health Care Spending

Health care spending in the United States originates from several sources: private businesses, households, the federal government, state and local governments, and other private sources (such as philanthropic entities). Households (at 27.7 percent) and the federal government (at 26.7 percent) account for more than half of all spending. Private businesses and state and local governments each contribute 20.6 percent and 17.4 percent, respectively (see Figure 3). All are affected by this cost burden.

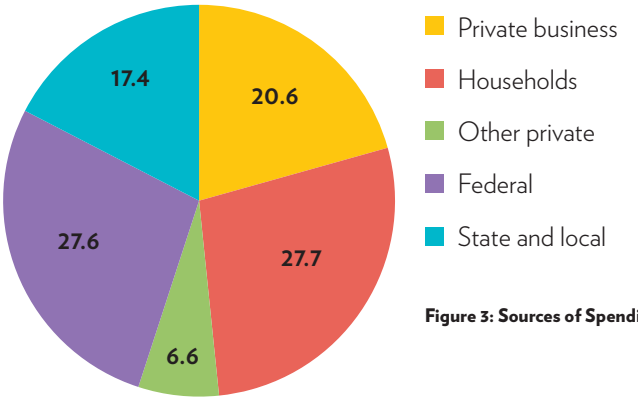


Figure 3: Sources of Spending (Percent)

Effect on Individuals

As health care costs rise, individuals pay higher premiums for insurance and spend more in out-of-pocket expenses. For decades, premiums have grown faster than most wages, reducing the real income of families. Health insurance premiums already amount to 23 percent of median family income according to a recent study. If these trends continue, the average premium for a family plan would exceed $24,000 by 2021 and absorb 31 percent of median family pay.[6]

Out-of-pocket expenses, such as co-pays and deductibles, also are growing. Between 2000 and 2011, these expenditures rose by 53 percent.[7]

Rising premiums, out-of-pocket costs, and other expenses offset gains in family income. A 2011 RAND Corporation study looked at the growth of household health costs, including insurance premiums, out-of-pocket expenditures, and taxes devoted to public health care programs, over a 10-year period, from 1999 to 2009. The study found that health spending nearly doubled over the period, absorbing most income growth. For a median-income family with two children, only $95 more per month was available to spend in 2009 than 10 years earlier.[8]

Rising medical costs, including premiums, affect Americans at all income levels but particularly those in the middle- and low-income ranges. A 2012 Kaiser Health tracking poll found that about four in 10 (39 percent) of those who earn less than $40,000 a year reported problems paying for medical care—nearly twice as many as those making between $40,000 and $90,000 a year (22 percent) and three times as many as those earning $90,000 or more a year (13 percent).[9] Moreover, having health insurance does not eliminate the financial burden of medical costs. In 2010, 20.2 percent of households that had health insurance reported problems paying medical bills.[10]

Impact on Federal and State Governments

Both federal and state governments face mounting health care expenditures that consume larger shares of their budgets. Federal health care spending for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP); insurance exchange subsidies under

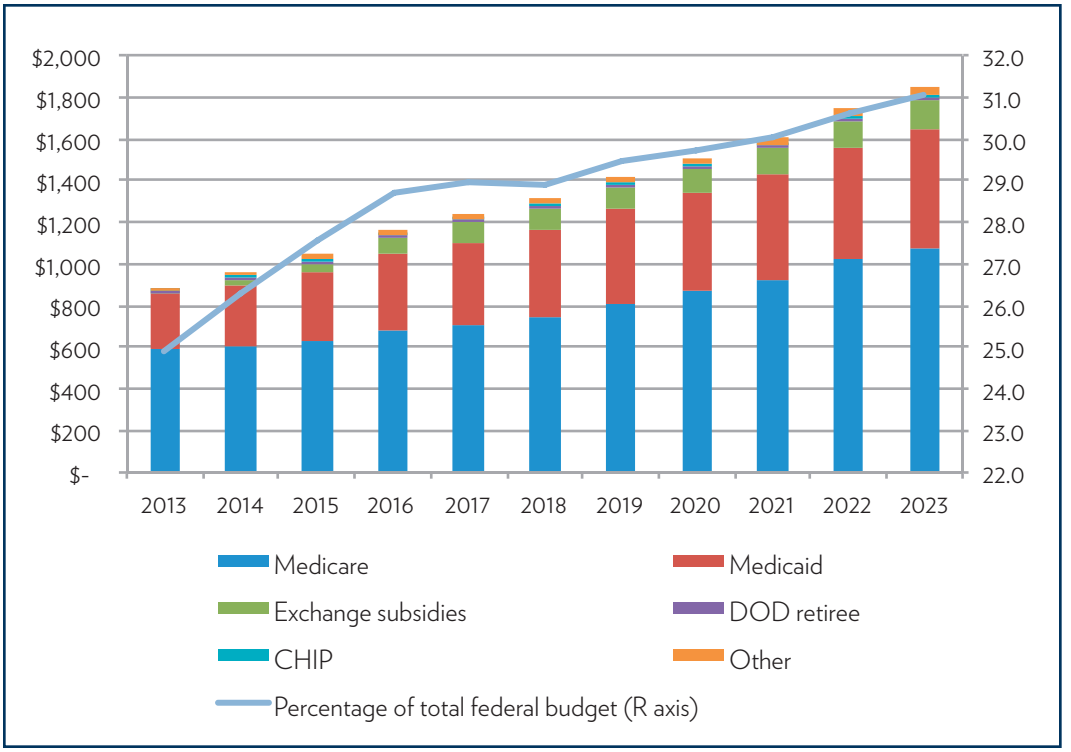


Figure 4: Federal Health Care Costs (Billions)

the ACA; and U.S. Department of Defense retiree health care costs is projected to increase from $885 billion in 2013 to $1.85 trillion in 2023. These costs will steadily consume a rising share of the nation's budget—from 25 percent in 2013 to 31 percent in 2023 (see Figure 4).[11]

Similarly, state government outlays for health care are growing, chiefly because of Medicaid. States currently contribute approximately 43 percent of the total costs for Medicaid coverage, spending $191 billion in 2013. But rising enrollment, expansion of the eligible population (resulting from the ACA), and greater costs of care will push state spending higher to $317 billion in 2021. This rise will occur even as the state share of costs falls slightly to 40 percent overall as the federal contribution for the newly expanded population stabilizes at 90 percent after a few years.[12]

For both federal and state government, growing health expenses are reducing the funds available for important public investments in workforce training, education, infrastructure, and research, to name a few areas. This trend will only accelerate. In fact, at the state level, total Medicaid spending (state and federal dollars) already exceeds total state and federal spending for kindergarten through 12th-grade education.[13] These reductions in public investments potentially threaten future economic growth and real family income. Rising health costs also add to the national debt, possibly raising future interest rates and creating more economic volatility.

It should be noted that Medicare and Medicaid spending is not evenly distributed across all beneficiaries. Some individuals—called *dual eligibles*—receive both Medicare and Medicaid. These individuals tend to be frail, poor, and disabled, often with chronic diseases and cognitive problems. Medicare serves as their primary insurance, covering acute care and hospitalizations, while Medicaid is used to cover other services, such as dental and long-term care. The dual-eligible population is expensive for both programs. In 2008, dual eligibles made up 20 percent of the Medicare population but 31 percent of total spending, 15 percent of the Medicaid population but 39 percent of total spending.[14] Many of the costs are devoted to treating chronic conditions and providing long-term care services and support.

Effect on Businesses

Businesses pay approximately 79 percent of the health insurance premium for single coverage and 68 percent of the premium for family coverage.[15] Chiefly for this reason, business health care outlays grew from $364 billion in 2000 to $558 billion in 2011, almost a 35 percent increase.[16] This growth has occurred even as the share of the under-65 years of age population receiving employer-based insurance has fallen steadily, from 69.2 percent in 2000 to 58.3 percent in 2011.[17]

For a typical policy covering a family of four, the employer contribution to yearly premium costs rose from $4,819 in 2000 to $10,944 in 2011. Over the same period, the employee contribution rose from $1,619 to $4,129.[18]

Many business leaders contend that rapidly rising health care costs inhibit job growth and lower business competitiveness. For industries that compete globally, such as manufacturing, high health care costs can place U.S. firms at a disadvantage in terms of labor rates. A recent study found that U.S. manufacturers had higher hourly labor charges devoted to health benefits ($2.38 in 2005 dollars) than Canada ($0.86), Japan ($0.68), Germany ($1.70), the United Kingdom ($0.40), and France ($2.17).[19] Such costs force U.S. manufacturers to be more productive than their foreign counterparts or hold down wages to remain competitive. However, little empirical research exists on how health costs affect jobs, profits, or competitiveness across the entire economy, and economists are divided in their opinion as to how health spending affects business performance.

Reasons Behind the High Cost of American Health Care

Several factors contribute to high health care spending in the United States, many of which are interrelated:

- Physician, facility, and drug costs are high.
- Americans use a higher proportion of expensive medicine.
- Care is fragmented and uncoordinated.

Comparison of Costs for Common Procedures											
	Argentina	Spain	France	Canada	Germany	Chile	Australia	Switzerland	U.S. low	U.S. average	U.S. high
Normal delivery (Physician fee)	163	329	449	536	226	890	1,837	NA	2,397	3,096	5,407
Normal delivery (facility and fee)	1,188	2,765	3,541	3,195	2,157	2,992	6,846	4,039	7,262	9,775	16,653
C-Section (Physician fee)	193	428	938	606	402	1,084	2,118	NA	2,688	3,676	6,593
C-Section (fee and facility)	1,541	3,097	6,441	5,980	3,441	3,378	10,566	5,186	10,545	15,041	26,305
Cataract (Physician fee)	157	420	426	699	609	1,048	1,311	NA	651	922	1,839
Cataract (fee and facility)	564	1,867	1,938	2,358	2,514	2,829	3,591	2,566	2,418	3,738	8,143
Appendectomy (Physician fee)	148	231	776	408	258	724	782	NA	674	1,001	2,044
Appendectomy (fee and facility)	953	2,245	4,463	5,606	3,093	4,221	5,467	4,782	8,156	13,851	29,426
Hip Replacement (Physician fee)	461	1,088	1,288	697	644	1,992	2,883	NA	1,983	2,888	5,196
Hip Replacement (fee and facility)	3,365	7,931	10,937	16,945	11,418	13,409	27,810	9,574	25,061	40,364	87,987
Routine office visit (Physician fee)	10	11	30	30	40	38	NA	64	68	95	176
CT Scan (abdomen)	103	118	183	124	354	234	NA	437	243	630	1,737
MRI	118	230	363	NA	599	502	NA	928	522	1,121	2,871

- Consumers with health coverage do not weigh costs when making health care decisions.
- The traditional fee-for-service payment model promotes fragmentation and higher spending.
- Administrative expenses are high.
- Unhealthy lifestyle choices and behaviors add to health burdens.
- End-of-life care in the United States is expensive.
- Provider consolidation in certain markets can lead to higher-priced services.

All of these factors lead to the United States having the highest health care costs among developed countries, even though U.S. consumers see their physicians and check into hospitals less frequently than most other OECD countries.

Physician, Facility, and Drug Costs Are High

Unit costs in the United States for physicians, facilities, and medications are more expensive, often markedly, than in other countries—a fact that numerous studies and price surveys that look at medical costs in the United States and abroad have confirmed. For example, price surveys conducted by the International Federation of Health Plans in 2011 and 2012 examined fee schedules in a variety of countries, comparing them with low, average, and high (95th percentile) prices in the United States (see table above).[20]

The surveys found that the average cost for interventions in the United States was almost universally more expensive than similar care elsewhere; even the lowest U.S. prices often exceeded those of all other countries. For example, the average cost for a normal

delivery (birth) in the United States, including facility expenses, was 2.7 times more than in France and 1.4 times more than in Australia, which had the second-highest fee. The costs of diagnostic procedures such as imaging show similar results. The average U.S. price for a standard magnetic resonance imaging (MRI) scan was 21–850 percent higher than in all other countries surveyed.

Prices *within* the United States also show significant variation. For example, the highest (95th percentile) cost for a hip replacement was 251 percent more than the lowest reported cost. For a standard MRI, the cost difference was 450 percent.

Not surprisingly, physician fees—both public and private—tend to be higher in the United States than anywhere else. In particular, fees that U.S. specialists charge are among the highest. A 2011 study found that American primary care and orthopedic physicians charge more for each service than their counterparts in Australia, Canada, France, Germany, and the United Kingdom.[21] Office visits to primary care physicians cost slightly more in the United States (27 percent more for public, 70 percent more for private), but fees to orthopedic surgeons for hip replacements were much higher (70 percent more for public, 120 percent more for private). U.S. primary care and orthopedic surgeons also earned higher incomes ($186,582 and $442,450, respectively) than their foreign counterparts.

Finally, U.S. pharmaceutical prices tend to be among the highest in the world, particularly for drugs that remain under patent controls. An OECD study reported that U.S. drug prices were at least 60 percent higher than those in five large European countries (2007 data). A report by the Commonwealth Fund showed that 30 of the most commonly prescribed brand-name drugs were one-third higher than in Canada and Germany and more than double the prices in Australia, France, the Netherlands, and the United Kingdom.[22] Interestingly, however, the most commonly prescribed generic drugs were all less expensive in the United States, confirming that the substitution of generic drugs for brand-name drugs can save money.

Americans Use a Higher Proportion of Expensive Medicine

A question often asked is whether Americans use too much care. It turns out the answer is mixed. Compared with other countries, Americans visit physicians less frequently (3.9 visits per capita in the United States versus the OECD average of 6.5), experience fewer hospital discharges per 1,000 people (130.9 versus the OECD average of 158.1), and have shorter hospital stays (4.9 days on average versus the OECD average of 7.2 days). However, when Americans seek treatment, they more frequently use expensive medical technology and costly procedures.

Imaging is used at a high rate in the United States. Although an average of 46.3 MRI studies are given per 1,000 individuals throughout the OECD, the U.S. rate of 97.7 per 1,000 is more than twice that (Germany is closest to the United States, with an MRI study frequency of 95.2 per 1,000). The frequency of computed tomography (CT) scans tells a similar story, with a U.S. rate of 265 per 1,000 people—also more than twice the OECD

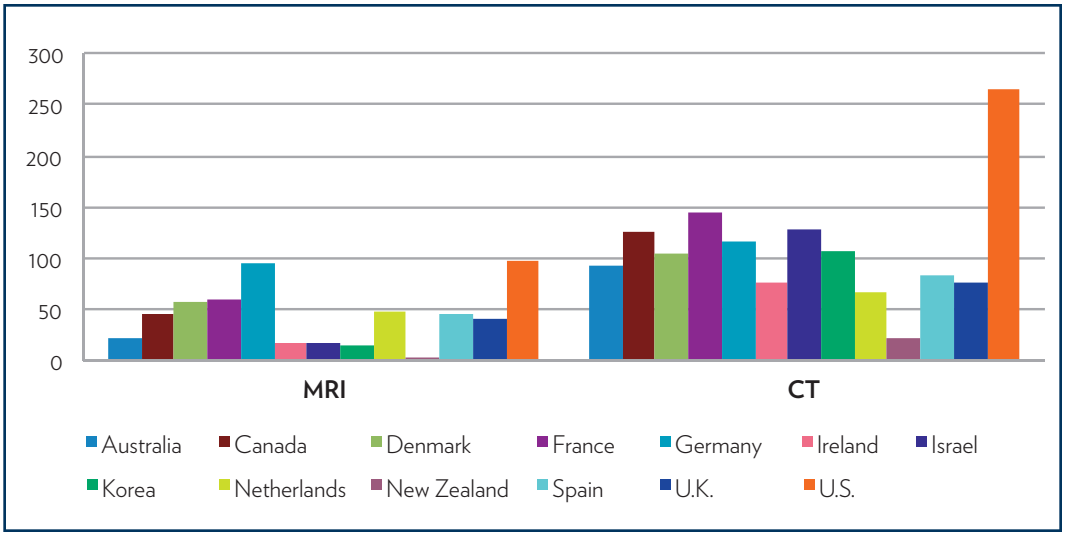


Figure 5: Imaging per 1,000 Population (2010 or Nearest Year)

average of 123 per 1,000. In fact, no other OECD country comes close to the U.S. rate for CT scans.[23] (See Figure 5.)

Americans also undergo expensive medical operations at a high rate. Knee-replacement surgery in the United States occurs 213 times for every 100,000 people, while the OECD average is just 118.[24] Only Germany had the same frequency of knee procedures as the United States. The United States also had the third-most frequent use of coronary angioplasty across the OECD, coming in at 327 procedures per 100,000 people, while the OECD average was half that at 188. Only Belgium and Germany had higher rates of angioplasty than the United States.

Somewhat unexpectedly, the United States was not among the leaders in hip replacement surgery. Although the U.S. rate of 184 per 100,000 people was still above the OECD average of 154, 13 other countries, including Germany and France, had even higher rates. However, the cost of hip replacement in the United States was 33 percent higher than in Germany and 17 percent higher than in France.[25]

Care Is Fragmented and Uncoordinated

Most Americans seeking treatment must enter and navigate a fragmented world of care delivery. Providers offer different services in different locations. Each retains his or her own patient information, billing procedures, and approaches to care. Minimal clinical information on patients is transferred across care settings, and consultation among providers is infrequent. The result: unnecessary and redundant services, errors and rehospitalizations, delays in treatment, patient dissatisfaction, and excessive expense.

Failure to coordinate patient care across providers is a common complaint. One survey reported that nearly half (47 percent) of all adults experienced one or more failures of care coordination.[26] The failures included the following areas:

- One-quarter (27 percent) of adults who had a medical test in the past 2 years reported that either no one informed them of the results or they had to call repeatedly to find out results.
- One in four adults (23 percent) said that their physicians failed to provide important information about their medical history or test results to other providers who should have it. Nearly one in five (18 percent) reported that test results or medical records were not at their physician's office in time for appointments.
- For adults who have three or more physicians involved in their care, coordination problems between primary care physicians and specialists are common. Eighteen percent reported that their specialist did not receive basic medical information from their primary care physician, while nearly one-quarter (24 percent) reported that their physician did not receive a report from a specialist following a visit.

Elderly patients in particular experience fragmented care. A recent study found the following:[27]

- The average patient sees seven physicians per year across four practices.
- The average surgery patient is seen by 27 different health providers.

One consequence of poor care coordination is hospital readmission. Studies have shown that up to 25 percent of elderly patients must return to the hospital after discharge. Although some of the readmissions are for scheduled follow-up care or for unrelated illnesses, a large number result from failures to educate patients on their follow-up needs and connect them with clinical resources outside the hospital. Readmission costs for Medicare patients alone have been estimated at $26 billion annually, with more than $17 billion for return trips that would not have happened if patients had received the proper care.[28] (Medicare has launched a new initiative to reduce hospital readmission rates, described later in this chapter.)

Care coordination is fundamental to improving the efficiency and quality of care delivery. An Institute of Medicine (IOM) study examined 9 million Medicaid-only and Medicaid/Medicare dually enrolled patients in five large states.[29] About 10 percent had patterns of extreme uncoordinated care. These patients had high numbers of different prescribing and treating physicians, used excessive or inappropriate numbers and types of prescriptions, relied on many pharmacies for their medications, and frequently visited the emergency department (ED) for nonemergency or preventable care. These uncoordinated care patients accounted for an average of 46 percent of drug costs, 32 percent of medical costs, and 36 percent of total costs for the population. Researchers concluded that 35 percent of the costs for these patients would have been avoidable with improved care integration, enhanced and targeted interventions, and care coordination among providers.

Consumers Do Not Weigh Costs When Making Treatment Decisions

Consumers who have health coverage do not shop for the provider who offers the best value—in other words, low-cost treatment and high-quality care. Instead, they shop for the health plan that offers the most affordable monthly premiums, the type of benefits they want, and the level of cost sharing (co-pays and deductibles) that they can manage. After that decision is made, payment for health care chiefly becomes the responsibility of a third party—the insurer—and consumers become insulated from the cost decisions they make. Moreover, when given options, consumers tend to choose high-cost treatment over lower-cost options of equal quality.

Numerous studies have shown that consumers generally equate high cost with high quality. For example, a recent study placed consumers in scenarios in which physicians presented diagnostic and treatment options that differed marginally in expected effectiveness but varied substantially in price.[30] The prices assigned to different treatment options were chosen to approximate real-world variations in medical treatment costs. In some scenarios, the patient would bear the extra cost of the most expensive treatment out of pocket; in others, the insurer bore the extra cost. Not surprisingly, most participants did not consider costs when deciding between comparable options and generally resisted the less-expensive option. Barriers cited include preference for the best-care option regardless of cost, lack of interest in costs borne by society, dislike of insurance companies, and self-interest. These responses were similar regardless of whether the participant thought that his or her share of costs would be higher.

"…the fee-for-service mechanism of paying physicians is a major driver of higher health care costs in the U.S. It contains incentives for increasing the volume and cost of services, whether appropriate or not; encourages duplication; discourages care coordination; and promotes inefficiency in the delivery of medical services."

—National Commission on Physician Payment Reform, March 2013, http://physicianpaymentcommission.org

Other studies have shown that specific information is needed on costs *and* quality to encourage consumers to choose value in health care.[31] Most current reporting of health care quality and cost is not sufficiently tailored to individual consumers to affect their choice. It is often too complicated, too impersonal, and too difficult to apply to the real-life choices the consumer faces. Studies suggest that consumers want physician-specific cost and quality data and information on their personal out-of-pocket exposure before considering lower-cost options. Indeed, experiments have shown that cost information must be combined with strong quality signals to help steer consumers toward higher-value choices.[32]

Other research has shown that consumers are more likely to consider cost if they have some financial "skin in the game," such as those with high-deductible health plans or other types of greater cost-sharing exposure. Consumers interested in value are those who have benefit designs that encourage cost-conscious choices, such as reference-based pricing (which limits benefits for certain procedures to a specific dollar amount).[33] Such schemes, however, still must include good information on quality.

Traditional Fee-for-Service Payment Promotes Spending

Fee for service, which compensates physicians for each service they deliver, is the most common payment model for health care in the United States. Currently, about 79 percent of all private workers (and 73 percent of all state and local government workers) who are enrolled in health insurance are in fee-for-service plans.[34]

Most policymakers see fee for service playing a major role in driving up health care spending. The model provides a financial incentive for providers to maximize the amount and cost of the services they deliver. At the same time, it does not reward superior care, better outcomes, improved efficiency, or care coordination.[35]

Fee-for-service payments will continue to have a place in the U.S. health care system, but it is far too prevalent today. For this reason, serious proposals to control health care spending invariably recommend a transition away from fee for service to alternative payment models that encourage greater efficiency. Notable alternatives include bundled payments (a single payment for the total cost of a set of services or an episode of care) or risk-based premiums that provide patient care on a fixed amount per period, usually a month or year. Such payments provide a framework for rewarding efficiency and quality. Savings realized by spending less than the "bundle" rate or fixed premium can be retained and used to reward providers for meeting cost and quality goals.

Administrative Costs Are High

Administrative costs for health care in the United States are high without enhancing value. According to the IOM, health care administrative costs in the United States are as much as $361 billion (2009 dollars). Approximately $168 billion to $183 billion of that cost could be eliminated if the system were simplified and best practices used universally. Labor is the cost driver. Not only must providers hire staff dedicated to managing claims and reimbursements, but the average physician spends about 3.8 hours a week—more than three work weeks a year—interacting with payers. This high workload is unique to the United States and reflects the numerous steps involved in submitting claims and receiving payment. It is also exacerbated by fee-for-service payments, in which each claim must be submitted, reviewed, and processed, and our fragmented network of payers and providers.[36]

Claims submission and reimbursement are the most burdensome steps. Providers must contract with insurers, maintain benefits databases, determine patient insurance and cost

sharing, collect copayments, check prior authorization, code services delivered, and submit claims. Providers who contract with multiple plans must adhere to different processes, each with unique benefit rules and restrictions. Finally, after claims have been submitted, they must undergo review, and high rates (10–15 percent) of initial nonpayment occur because a certain step was overlooked or a piece of information missing. Claims then must be resubmitted. As much as $168 billion to $183 billion in excess administrative costs each year can be traced to such process inefficiencies.

The cost of administering health care in the United States may never be as low as in Canada, for example, which operates a single-payer system, but all agree that there is substantial room for improvement. Replacing fee-for-service payments with bundled payments or capitation would go a long way toward reducing the volume and complexity of billing. Likewise, automating most "back office" administrative processes would eliminate substantial inefficiencies.

Unhealthy Lifestyles

Americans' personal health choices can increase the demand for health services and expensive interventions. Poor lifestyles can lead to chronic illnesses, such as heart disease, stroke, cancer, diabetes, and arthritis.* These ailments cause approximately 70 percent of all deaths in the United States and afflict one in two adults.[37] In 2007, the Milken Institute estimated that the most common chronic diseases cost the economy more than $1 trillion annually (including lost productivity), possibly reaching $6 trillion by the middle of the century.[38] The cost of medical treatment alone was estimated at $277 billion (for noninstitutionalized individuals).

Many believe that chronic disease is largely preventable. Tobacco use and excessive alcohol consumption cause some illness, suffering, and early death related to chronic disease, but obesity—caused by lack of physical activity and poor nutrition—is responsible for a large share of heart disease, stroke, type II diabetes, and certain types of cancer. One study estimated that obesity and the ailments it spawns likely cost the nation at least $147 billion per year in medical costs (2008 estimate), with medical spending for the obese being about 42 percent higher than for someone of "normal" weight.[39]

Obesity is a concern worldwide, but the United States continues to have the highest rate (see Figure 6).[40] In 2009–2010, 35.7 percent of Americans over 15 years of age were obese. In contrast, the same age group in Japan had an obesity rate just below 4 percent, and the United Kingdom stood at 23 percent. The closest country to the United States in terms of obesity prevalence was Mexico, with a 30 percent rate in 2006 (latest data).

*Crime, environment, socioeconomic status, and other factors also can affect the prevalence of disease and mortality and the overall cost of health care, but policies designed to address these conditions are beyond the scope of this report. Instead, this report focuses on behaviors and lifestyles that many experts consider to be largely preventable and influenced by personal choice and public health initiatives.

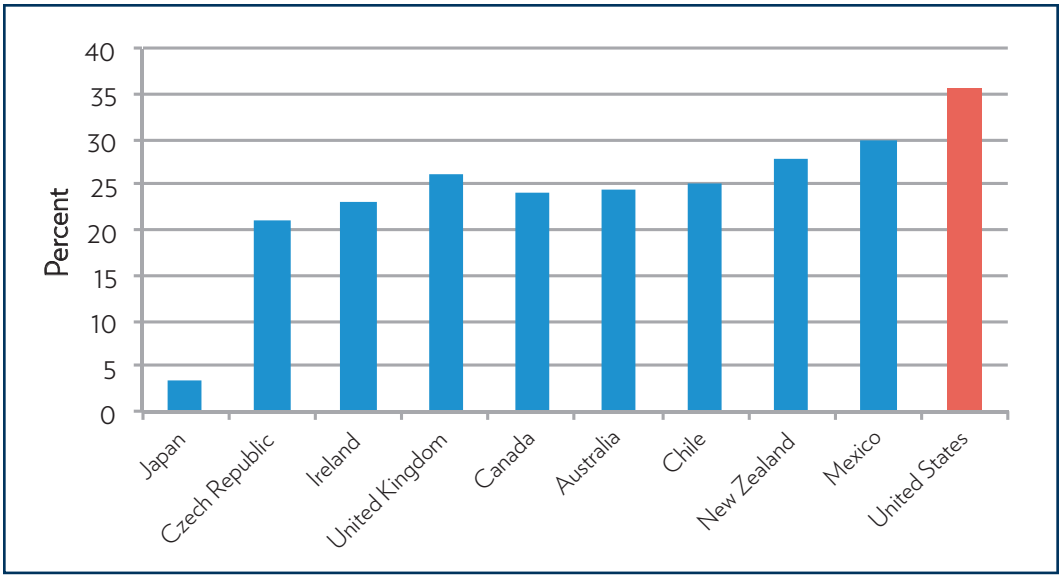


Figure 6: Obesity Prevalence Age 15+ (2010 or Nearest Previous Year)

some states than in others. In 1990, 10 states had an adult obesity rate of less than 10 percent of the adult population, and no state had a prevalence equal to or greater than 15 percent. In 2010, all states had an adult obesity rate of at least 20 percent. Thirty-six states had an obesity prevalence equal to or greater than 25 percent, and 12 of these states (Alabama, Arkansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Oklahoma, South Carolina, Tennessee, Texas, and West Virginia) had a prevalence equal to or greater than 30 percent.[41]

Of particular concern is childhood obesity. Currently, about one in eight preschoolers is obese, and statistics indicate that overweight preschoolers are five times more likely than their normal-weight peers to become obese or overweight adults. Recent data (2011) suggest some progress: Obesity rates decreased slightly in 19 of 43 states and territories, but the reductions were small.[42]

Evidence shows that obesity can be curbed or prevented by facilitating a handful of key behaviors:

- Choosing healthier foods (whole grains, fruits and vegetables, healthy fats and protein sources) and beverages
- Limiting unhealthy foods (refined grains and sweets, potatoes, red meat, processed meat) and beverages (sugary drinks)
- Increasing physical activity and limiting television time, computer entertainment, and other "sit time"

Lifestyle changes often are more effective—and less costly—than medical treatment. For example, simply walking 30 minutes a day can cut the rate of individuals becoming diabetic by more than half, and it lowers the risk of people over 60 years of age becoming diabetic by almost 70 percent.[43]

Futile End-of-Life Care in the United States Is Costly

Americans consume a significant share of their lifetime medical costs in their last year of life. Many undergo aggressive treatments and repeated hospitalizations, even though more appropriate and less expensive hospice and palliative care may be available and preferred by the patients themselves. One study, using the most recent data available, found that average Medicare payments for a patient in his or her last year of life averaged $38,975 (2006 dollars), with more than half of that cost attributed to hospital-based care.[44] The total cost for these patients accounts for about a quarter of total Medicare spending and an unknown amount of Medicaid spending (primarily for nursing home stays). Equally significant is the high out-of-pocket costs for end-of-life care; a 2010 study estimated average out-of-pocket costs at $12,120 per patient in the last year of life, with some paying as much as $49,751 (95th percentile).[45]

The intensiveness of medical care at the end of a patient's life helps determine overall costs. Many patients—even those with chronic or terminal diseases—would prefer to receive treatment in outpatient settings and even at home,[46] yet evidence suggests that the intensity of treatment that a patient receives is largely dictated by the supply of available care, such as the number of hospital beds and specialists, and not by the patient's wishes. For example, in 2007, the average hospital stay for a patient in the last 6 months of life was 10.9 days, but patients in Manhattan spent an average of 20.6 days in the hospital during their last six months of life, while those in Ogden, Utah, spent an average of just 5.2 days—50 percent less than the national average and four times less than in Manhattan.

The number of providers a patient sees toward the end of life also appears sensitive to regional supply versus actual need. On average, 36.1 percent of chronically ill Medicare patients see 10 or more doctors in the last 6 months of their life (2007 data), but the percentage varies nationwide, ranging from a high of 58.1 percent in Royal Oak, Michigan, to a low of 14.2 percent in Boise, Idaho.[47]

Fortunately, the trend in long hospital stays and multiple physician visits has been declining, and newer data should reflect further declines as hospice care capacity and utilization increases. However, the fact remains that patients near the end of their life are often guided toward invasive and intensive treatment in place of hospice or palliative care. This is unfortunate, because hospice has been shown to greatly improve the quality of care for patients, reduce symptom distress, and potentially lower costs. A recent study found that subjects enrolled in hospice for 53–105 days prior to death had significantly lower mean total Medicare expenditures than those who did not enter hospice ($22,083 versus $24,644). Hospice enrollees during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, 30-day hospital readmissions, and in-hospital deaths.[48]

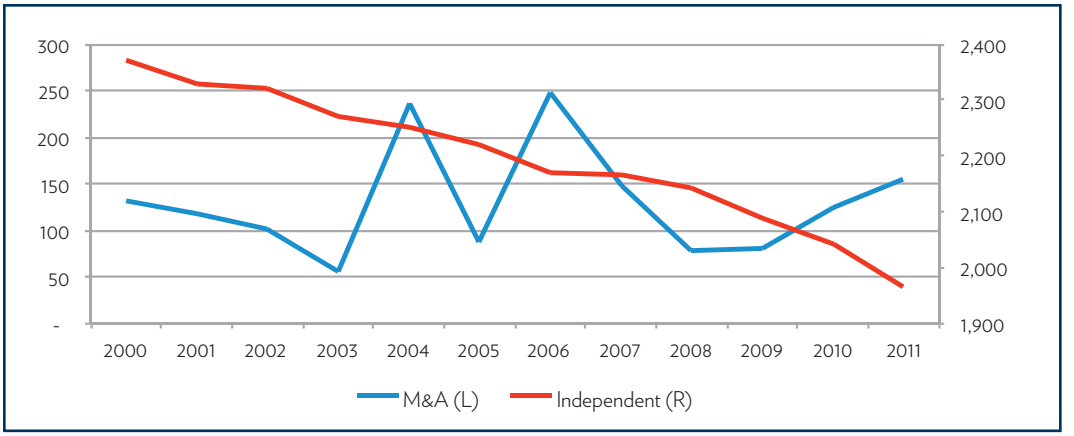


Figure 7. Hospital Mergers and Independent Hospitals

Provider Consolidation and the Risk of Market Power

Provider consolidation among and between hospitals and physician groups is an important trend in health care. Provider consolidation can create more efficient organizations and provide higher-quality care, an issue that is discussed in Chapter 2. However, provider consolidation also can create health systems that dominate markets, potentially creating upward pressure on the price of services.

Consolidation is rampant throughout the health care industry, with a great deal of it focused on increasing market share. Much activity over the past 20 years has involved hospital mergers and acquisitions (horizontal integration). Less competitive hospitals have been absorbed by more successful institutions, and large hospitals have joined together to create multihospital networks. Despite this activity, the total number of hospitals has remained relatively flat—4,915 in 2000 compared with 4,973 in 2011—but the number of independent hospitals has fallen from 2,373 to 1,996 (see Figure 7).[49]

Hospitals also are merging with physician practices and other provider groups to create larger health systems that offer a wide array of in-patient, out-patient, clinical, and diagnostic services (vertical consolidation). In 2000, 51 percent of all hospitals were in health systems that included nonhospital services. By 2011, this figure had risen to 60 percent. In addition, physician groups are merging to create larger networks, and these networks will likely join hospitals as trends continue.

Unfortunately, the goal of much consolidation activity often is to increase the market presence of a hospital or health care system. This type of consolidation can create "must-have" hospitals or provider networks that insurers must include in their plans, giving the providers a strong upper hand in price negotiations.

A recent study analyzed private insurer payment rates to hospitals and physician practices in eight market areas, focusing on price variation across and within markets.[50] Average inpatient payment rates in the eight market areas ranged from 147 percent of Medicare

inpatient payment rates in the eight market areas ranged from 147 percent of Medicare rates in Miami to 210 percent in San Francisco. The variation of prices within market areas was more striking. In Los Angeles, for example, the highest and lowest (25th percentile) payment rate to a hospital differed by almost a factor of five. The study found that hospitals with higher payment rates (for the same services) tended to be the larger hospitals, an expected result, because larger hospitals are likely to have more leverage with health plans.

A 2010 report by the Massachusetts Attorney General's Office found similar results when examining provider claims data and financial records in the state.[51] The report painted a picture of a broken marketplace. Among the findings:

- Price variations are correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospital or provider groups in a geographic region (for example, the average price variation among large physician groups was 230 percent).
- Price increases, not increases in utilization, caused most of the rise in health care costs during the past few years in the state.
- Higher-priced hospitals are gaining market share at the expense of lower-priced hospitals, which are losing volume.

Although consolidation often leads to higher costs, it rarely leads to better care. In fact, research has consistently found little change or even poorer quality resulting from hospital consolidation.

An indepth study recently conducted by the Catalyst for Payment Reform concluded:[52]

> *"Consolidation in the health care sector is ubiquitous. And despite the potential benefits, there is also fear—based on well-documented historical trends—that unless we manage it carefully, massing provider market power will lead to even higher prices and revenues."*

Identifying Solutions

Many problems plague the U.S. health care system, leading to ever-rising costs. These include high prices for all services and frequent use of expensive medicine, fragmented care, lack of consumer motivation to control spending, fee-for-service charges, poor population health, and costly end-of-life care. However, a common thread links many of these issues: Most health care remains uncoordinated, and payment models do not provide sufficient incentives to manage costs and improve quality. The chapters that follow will explore how these problems can be addressed and how the organization and compensation of health care delivery can be transformed to stimulate higher-quality outcomes and improved cost management.

2. The Evolving Health Care System

The health care system in the United States is evolving and will look much different 10 or 20 years from now. Some changes result directly from the ACA, and some have been emerging for several years, possibly accelerated by the ACA. Two major trends shape this future.

First, the organizational model of health care is shifting—albeit slowly—toward more coordinated, patient-centered care. Instead of providers and hospitals delivering and charging for individual services with little coordination among them, new organizations are forming that integrate hospital and physician care across multiple settings, using payment schemes that reward efficiency and quality. The Medicare program is encouraging formation of these organizations, but the trend is beginning to take root throughout the health care system in an effort to control costs and improve quality.

A second trend involves the dramatic expansion of the U.S. population covered by health insurance. Starting in 2014, the ACA will provide subsidies to individuals who have incomes at or below 400 percent of the poverty level to purchase private health insurance. Medicaid rolls will also be expanded under new eligibility criteria. Both actions could increase the number of people enrolled in public and private health insurance by 42 million in 2022 compared with 2013. (If all states eventually elect to expand their Medicaid eligibility, this figure could rise by another 22 million.) To provide coverage to this new group and meet the increased demand for care, new types of health organizations and plans must be created.

Together, both trends offer an opportunity. The organization of health care is changing, and care capacity will need to grow to meet new demand. Policymakers must encourage the growth of those delivery systems that coordinate services, focus on quality, and manage costs.

The Trend Toward Patient-Centered, High-Performing Care Delivery

Patient-centered, high-performing care is an old concept that is gaining new interest. The approach involves hospitals and provider organizations working together to integrate and coordinate care across multiple treatment settings, using a team-based approach to

determine a patient's needs. In addition, the new model holds the organizations accountable for meeting cost-management and quality goals through global or fixed payments.

Patient-centered, high-performing health care delivery was an original goal of managed care organizations (MCOs) when they were first created. (Many immediately think "health maintenance organization (HMO)" when they hear the term *managed care,* but several models exist [see sidebar, "Managed Care Organizations and Strategies"].) A patient-centered, high-performing health care system possesses the following characteristics:[53]

- Providers have real-time access to clinically relevant information for each patient at the point of care, and all patients have access to their records through electronic health record (EHR) systems.
- Patient care is coordinated among multiple providers, and transitions across care settings are actively managed via a strong primary care structure.
- Providers (including nurses and other members of care teams) both within and across settings review each other's work and collaborate to reliably deliver high-quality, high-value care.
- Care is evidence based, the quality of care delivered is measured and tracked, and continuous improvements in quality and efficiency are encouraged.
- Financial incentives are based on achieving system performance and quality goals, not simply on achieving cost targets.

Many care systems today fall short of the goals expressed above, because they lack full integration, have limited ability to share patient records with network providers, fail to coordinate patient care across multiple treatment settings, and/or lack financial incentives to control costs and improve quality. Of course, notable exceptions exist, and several MCOs throughout the country deliver high-performing care (see sidebar, "Examples of High-Performing Care Systems").[54] However, most MCOs lack one or more defining characteristics of high-performing systems.

Enter the accountable care organization (ACO), a concept that has been under discussion for the past decade that essentially reintroduces the original concept of managed care as a high-performing health system. An ACO brings together different health care entities, such as providers (both primary and specialty), hospitals, and diagnostic centers, to oversee and coordinate a full range of care for a defined population of patients. ACOs coordinate care across multiple medical specialties and settings (both inpatient and outpatient), promote evidence-based care practices, and use information technology (IT) to record and share clinical data. ACOs must also control costs and meet quality goals. To insure this, ACOs are typically given global budgets that allow them to share savings within the organization when costs come in below established rates and quality measures are met. If quality and cost expectations are not met, then the organization risks losing such savings.

The federal government is promoting ACO formation using two programs that the ACA created for Medicare: the *Medicare Shared Savings Program,* which is designed to

Managed Care Organization Models

Several types of managed care organizations and strategies are used today. Five are described here:

1. A **health maintenance organization (HMO)** provides health coverage using a network of physicians, hospitals, and other health care providers. Many HMOs assign patients to a primary care provider (PCP) who coordinates care, arranges a patient's referral to a specialist, or authorizes admission to a hospital. Although most HMOs use PCPs as care coordinators, some HMOs have open-access plans that allow the patient to choose any PCP or specialist in the network without a referral.

   There are four styles of HMOs. A staff model HMO directly employs health care providers. The providers exclusively treat HMO members and typically are housed in HMO buildings. A group model HMO contracts with one or more group practices to provide health care services, and each group primarily treats HMO members. A network model HMO is like a group model, except that the group practices are open and provide services to non-HMO members. Independent practice association HMOs contract with individual physicians or with associations of physicians to provide HMO services; these providers typically see patients who are not HMO members as well.
2. A **preferred provider organization (PPO)** contracts with and negotiates fees with an assortment of physicians, hospitals, clinics, and other health providers. Typically, the patient is not assigned a PCP and may see any provider in the network without a referral. The patient can also see providers outside the network, but out-of-pocket costs are significantly higher in those cases.
3. A **point-of-service (POS) plan** has elements of both an HMO and a PPO. Members can use a PCP to coordinate their care, or they can self-direct to the provider of their choice in the network. Services coordinated through a PCP have lower out-of-pocket costs than self-referral care. As in a PPO, out-of-network care has the highest out-of-pocket cost.
4. An **accountable care organization (ACO)** can take a variety of forms and is most closely aligned with the original definition of an HMO but with a greater emphasis on quality of care. An ACO is an organization of health care providers who (1) provide coordinated care across multiple health care settings and (2) agree to be held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Hospitals, provider groups, diagnostic labs, and pharmacies all can be part of an ACO. To promote accountability, the organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Note: *A* ***medical home*** *is a strategy for coordinating care that can be used in any of the above models. In a medical home, each patient is assigned a PCP who navigates and coordinates the patient's care across multiple settings, ensuring that providers work together to deliver high-quality services.*

Examples of High-Performing Care Systems

In 2008, the Commonwealth Fund profiled 15 health delivery systems across the United States notable for their performance in delivering high-quality, integrated care as described in this chapter. The systems represented a variety of organizations and strategies and included the following institutions:

- **Integrated delivery system or large multispecialty group practice with a health plan.** Denver Health (Colorado), Geisinger Health System (Pennsylvania), Group Health Cooperative (Washington), HealthPartners (Minnesota), Henry Ford Health System (Michigan), Intermountain Healthcare (Utah), Kaiser Permanente (eight states and the District of Columbia), Marshfield Clinic (Wisconsin), New York City Health and Hospitals Corporation, and Scott & White (Texas)
- **Integrated delivery system or large multispecialty group practice without a health plan.** Mayo Clinic (Minnesota, Arizona, Florida) and Mayo Health System (Iowa, Minnesota, Wisconsin), MeritCare Health System (North Dakota), and Partners HealthCare (Massachusetts)
- **Private networks of independent providers.** Hill Physicians Medical Group (California) and North Dakota Rural Cooperative Networks
- **Government-facilitated networks of independent providers.** Community Care of North Carolina

Readers interested in learning more about these high-performance systems should consult the Commonwealth Fund report, "Organizing for Higher Performance: Case Studies of Organized Delivery."

help providers become ACOs, and the *Pioneer ACO Program,* which will help organizations and providers who are already experienced in coordinating patient care across multiple settings. Both programs establish a baseline payment rate to the ACO that reflects the current cost of treating patients under the standard Medicare fee-for-service arrangement. Both programs also require the ACOs to track 33 quality performance measures. ACOs that meet a certain savings rate and quality benchmarks can retain a portion of the savings below the baseline payment. The programs differ slightly in the options that serve to increase risk and reward.

The federal government anticipates that ACOs will yield savings in the Medicare program, and some early results support these expectations.[55] The concept has also attracted the interest of commercial payers that seek to control cost growth. As of May 2013, Medicare had approximately 220 ACOs in the Shared Saving Program and 32 in the Pioneer ACO Program,[56] but the consulting group Leavitt Partners reports that as many as 428 public and private ACOs exist throughout the country, operating in 49 states.[57] Despite these numbers, ACOs are represented in few insurance plans, and it will take many years

before they achieve significant market penetration. That is why it is important for payers—including large, self-insured organizations—to encourage the formation of ACOs.

If public and private payers can coax providers to create integrated systems of care that bear some risk in meeting cost and quality targets, such as an ACO, then a critical step for controlling spending growth might be realized. However, payers must insist on compensation systems that hold the organizations accountable for cost control and quality improvements. Otherwise, ACOs will be indistinguishable from other consolidated hospital and provider systems that fail to manage spending growth (see Chapter 1).

Other Provisions in the ACA That Help to Improve Care and Lower Costs

In addition to supporting the creation of ACOs under Medicare, the ACA includes initiatives to improve care coordination, reduce waste, and improve quality:

- Hospitals with high risk-adjusted readmission rates for certain conditions now face Medicare payment penalties, which can lower wasteful and inefficient care.
- Incentives under Medicare will encourage hospitals to adopt proven practices that substantially reduce their rates of hospital-acquired infections and other avoidable conditions; hospitals that still have rates in the top 25 percent will face reductions in Medicare payments. This practice has begun to reduce readmission rates.
- The Medical Loss Ratio rule penalizes insurance companies that do not spend the majority of their premium income on health care. If an insurance company spends less than 80 percent of premiums on medical care and quality (or less than 85 percent in the large group market), it must rebate the portion of premium dollars that exceeded this limit. This rule, in effect, ties premium costs more directly to the cost of health care.
- Starting in 2018, an excise tax on "Cadillac" insurance plans will affect plans that charge more than $27,500 for families and $10,200 for individuals. For these plans, the ACA will impose a 40 percent tax on the portion of health insurance over these amounts. After 2020, the premium threshold for the tax will increase at the rate of the Consumer Price Index. This tax can provide a market signal to consumers that they should seek more cost-effective care that delivers equivalent quality.
- The Patient-Centered Outcomes Research Institute will assess new medical tests, drugs, and other treatments as they are developed, providing continuously updated information for physicians and patients. Public and private payers can encourage providers to incorporate the latest information in their practices.
- The Independent Payment Advisory Board (IPAB) will devise changes to Medicare's payment system. Beginning in January 2014, each year that Medicare's per-capita costs exceed a certain threshold, the IPAB will develop and propose policies to reduce the inflation. Changes in Medicare's payment rates for certain services can help inform payment rates in other public and private programs.
- The State Innovation Models Initiative (administered by the U.S. Department of Health and Human Services [HHS]) is providing up to $300 million to support the development

and testing of state-based models for multipayer payment and health care delivery system transformation, with the aim of improving health system performance for residents of participating states. Twenty-five states have received an award.
- Through the Health Information Technology for Economic and Clinical Health Act, passed as part of the 2009 federal stimulus legislation, HHS is spending $25.9 billion to promote and expand the adoption of health IT. As part of this effort, more than $300 million is being provided to support regional and state efforts to create health information exchanges.

Expansion of Insurance Coverage

Mandates and incentives in the ACA will significantly expand insurance coverage throughout the United States starting in 2014 (see sidebar, "Insurance Coverage Mandate of the ACA"). According to the Congressional Budget Office (CBO), the insured nonelderly population in the United States (50 states and the District of Columbia) will grow from approximately 216 million in 2013 (81 percent coverage) to 258 million in 2022 (92 percent coverage). Most of this expansion will occur through Medicaid and federal subsidies given to eligible citizens (based on income) to purchase health insurance through authorized exchanges.

Medicaid will account for about a quarter of the insurance expansion, with CHIP enrollment staying relatively flat or falling as enrollees move to Medicaid. Medicaid is both a categorical and a means-tested program. Currently, states individually determine the poverty level (up to 250 percent of the federal poverty level [FPL]) for eligibility. Most states

Insurance Coverage Mandate of the ACA

The ACA requires that nearly every resident of the United States obtain health insurance by January 1, 2014. People who do not comply with the individual coverage requirement will be charged a penalty, assessed through the Internal Revenue Code, although exemptions from that requirement or its associated penalties are provided for several categories of people, including those who have taxable income below the threshold for mandatory tax filing, unauthorized immigrants, members of certain religious groups, people who would have to pay more than 8 percent of their income for health insurance, and those who obtain a hardship waiver. In 2016, the penalty for noncompliance with the requirement for obtaining insurance is set at the greater of $695 for an individual (up to three times that amount for a family) or 2.5 percent of income in excess of the filing threshold.

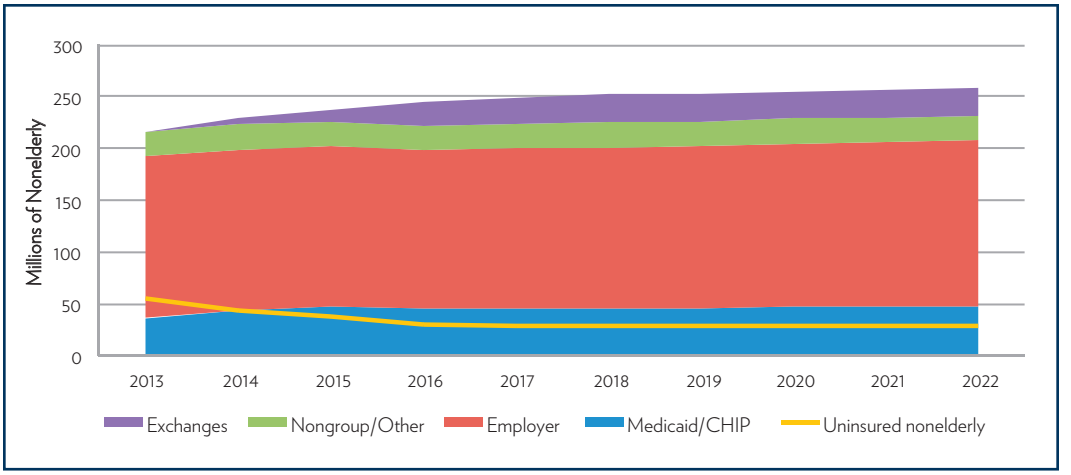


Figure 8: Insurance Coverage Growth Under the ACA

restrict coverage to children and pregnant women. Eligibility for parents is limited—below half of the FPL in most states—and few states covered childless adults before the ACA passed (before the ACA, covering childless adults required a waiver). Under the ACA, Medicaid will expand to cover most U.S. citizens under 65 years of age who have family incomes up to 138 percent (including income disregards) of the FPL, potentially bringing a large number of childless adults and low-income parents into the system.

The June 2012 U.S. Supreme Court decision concerning the ACA gave states the option to implement the expanded Medicaid benefits, bringing uncertainly to the number of individuals likely to obtain coverage. As of September 2013, 16 states had enacted Medicaid expansions, and another nine are leaning toward expansion; the rest are either undecided or currently against it.[58] As a result, the CBO estimates that only 11 million more individuals will be covered annually by Medicaid in 2022 than in 2013. However, if all states fully implemented the expansion, a possible 21 million more individuals might be covered in 2022 over 2013 levels.[59] Many are confident that all states will eventually administer the full Medicaid expansion. The accompanying chart, "Insurance Coverage Growth Under the ACA," depicts the CBO estimates of coverage, assuming that not all states expand Medicaid.[60]

Although almost half of the states have not committed to the Medicaid expansion, they are facing pressure to do so. Hospitals, clinics, and EDs will be where the uninsured turn for health care, and any uncompensated costs will likely be collected through higher provider prices and insurance rates, mostly affecting consumers and private payers. Cost shifting will be exacerbated by the phase-out of "disproportionate share hospital" payments, which subsidize the expense of treating large numbers of indigents.

The other major ACA action to increase coverage is the insurance premium subsidy credit. Starting in 2014, individuals who buy insurance through an authorized state or federal exchange will be eligible for a refundable tax credit on a portion of their health

insurance premiums. Individuals who have income levels between 100 and 400 percent of the FPL are eligible for the subsidy. In addition, all people who buy coverage through an exchange and receive a subsidy will have a cap on their total out-of-pocket spending, including deductibles, co-pays, and co-insurance. The CBO estimates that approximately 26 million individuals will purchase health insurance through the exchanges in 2022, with 21 million of those individuals receiving subsidies.[61]

As a result of both the Medicaid changes and premium subsidies, at least 42 million currently uninsured Americans will eventually receive coverage and join some type of organized health plan. All types of plans—those provided by Medicaid and those sold through the exchange—will face strong pressure to control health care costs. These tensions should help motivate the search for greater efficiency and value in how care is delivered.

Taking Advantage of Trends

The two trends discussed in this chapter have the potential to drive beneficial change in the health care system. The organizational structure of health care delivery is constantly changing. As care capacity increases to serve the expanded insured population, the organizational structure of the new capacity will influence existing models. If the focus is on coordination, cost control, and quality of care, then many providers will form new partnerships and alliances around the same goals.

State policy must encourage and facilitate these beneficial changes. How this can be accomplished is described in the next two chapters.

3. The State Role in Transforming the Health Care System

States can play a major role in transforming the health care delivery system. Using numerous policy levers, they can influence how the system is organized, motivate it to pursue greater efficiency and enhanced quality, and discourage market behavior that results in unreasonable price increases. Notable policy levers include:

- Government-sponsored health care spending programs such as Medicaid/CHIP, state employee health benefits, and health insurance exchanges;
- State laws and authorities governing insurance, scope of practice, provider rates, and medical malpractice
- State laws affecting market competition and consumer choice, such as antitrust enforcement and requirements for providers to report price and quality information
- The authority to invest in initiatives that improve population health and encourage citizens to live healthier lives
- The power of governors and legislatures to engage stakeholders in major public policy issues and create a process for change

In the past several years, states have begun to use their influence to change health care delivery and facilitate the trend toward more coordinated, quality-based care. Most of the focus has been on making Medicaid services more cost effective for the state and its beneficiaries, but as the health care system continues to evolve through expanded insurance coverage and the reorganization and consolidation of providers, states will need to consider how to strategically use all of their levers to help steer the system toward greater value.

Government Health Care Spending Programs

States are a major market participant in health care, directing how dollars are spent for Medicaid/CHIP and for state employee health benefits. States can use these investments to steer the health care system toward organizational structures that reward cost management and quality improvement. In addition, states can use rules that govern insurance exchanges to encourage the availability and selection of plans that also manage costs and provide a high quality of care.

Medicaid

States can use Medicaid dollars to influence how care is delivered. Medicaid covers about 21 percent of the U.S. population, or about 57 million people (point-in-time data, not annual per-person coverage). Coverage varies from about 12 percent of the population to as high as 31 percent in each state.[62,63] Enrollment in CHIP is much lower—about 5.3 million children.

Total federal and state Medicaid/CHIP outlays in 2011 (state and federal dollars) were $408 billion—about 15.1 percent of all national health care spending.[64] By 2021, total Medicaid/CHIP expenditures are expected to reach $957 billion, or 20 percent of all national health care expenses.[65] These dollars represent a significant share of the health care marketplace. Because states administer the program and manage all spending (both federal and state), they can use this purchasing power to prompt changes in how care is organized and delivered.

For more than a decade, states have worked to expand the capacity of Medicaid managed care in place of fee-for-service Medicaid (only Alaska, New Hampshire, and Wyoming do not operate some type of Medicaid managed care plan). About 74 percent (2011 data) of all Medicaid enrollees are now in some form of managed care, including comprehensive risk-based plans, primary care case management programs, and limited-benefit plans—up from 58 percent in 2002.[66] (Separate figures are not available for CHIP, but most states integrate Medicaid and CHIP managed care programs.)

Most Medicaid managed care is delivered through risk-based, comprehensive plans that typically use an HMO model in which enrollees must use a network of providers. In 2009, 47 percent of all Medicaid enrollees were in such plans, up from 15 percent in 1995. The plans provide comprehensive services, including coordinated care (particularly important for beneficiaries who have multiple chronic conditions), prevention initiatives, and education on healthy living. States pay the plans on a capitated basis—a set monthly fee per enrollee under the plan contract.[67] The plans assume the risk of meeting cost targets but can retain savings if they meet cost and quality goals.

Improved cost management and better-quality care are the primary motivations for expanding Medicaid managed care. Because Medicaid fee-for-service rates are already set so low, cost savings have been modest; however, the set monthly fee per enrollee provides more predictability in budgeting. In addition, the plans include quality initiatives that focus on the unique care needs of the population, such as obesity reduction, diabetes care, and maternal and infant health.[68] For these reasons, states are committed to expanding Medicaid managed care, and efforts are now focusing on the disabled and elderly dual-eligible population.

State Employee Health Programs

Health care benefits for state and local government workers represent a large share of the health care market. States provide health insurance coverage for about 3.4 million

state government employees and retirees. Another 8.3 million local government workers are covered by health insurance; in several states, local government employees are covered through state-administered health plans.[69] Together, state and local governments constitute the largest single health purchaser in most states, and this purchasing power can be used to shape how health services are delivered and paid for.

Unfortunately, most state and local governments have not taken full advantage of their market leverage to create or expand cost-effective health care delivery systems. Seventy-three percent of all state and local government workers enrolled in health insurance are in fee-for-service plans. Although these plans may have some procedures to manage costs, such as restricted provider networks, they do not emphasize coordinated care or create incentives for improving quality and reducing waste.

State and local governments can collaborate and use their health care dollars to purchase plans that employ coordinated care and financial incentives that reward quality and cost containment. Benefit managers can also include specific goals concerning the cost and quality of care in their contracts with insurers. In addition, employees can be given incentives to choose high-quality plans that control spending growth.

Wisconsin's Department of Employee Trust Funds (ETF) is an example of a state using its market presence to promote value-driven health care. The Wisconsin ETF purchases health care for more than 250,000 active state *and* local employees and 115,000 retirees and their dependents, making it the largest purchaser of employer coverage in the state.[70] The state has moved most of its employees into managed care. Ninety-eight percent of the state and local workers choose coverage from among 16 HMOs and two preferred provider organizations. Most of the plans offer disease management, wellness, and prevention initiatives.

The Wisconsin Insurance Board ranks and assigns each available health plan to one of three "tier" categories based on its efficiency and quality of care. The tier ranking of each health plan determines premium contributions, with Tier 1 offering the lowest rates. This approach encourages members to choose the plans that are most efficient in providing quality health care. It also encourages plans to maintain a Tier 1 rating so they can attract more enrollees.[71]

Oversight of Health Insurance Exchanges

The creation of health insurance exchanges—a requirement of the ACA—gives states an opportunity to influence the type of health plans offered to the public. Health insurance exchanges provide an online marketplace in which individuals buying insurance on their own and small businesses with up to 50 employees (expanding to 100 employees in 2016 and more at a state's discretion in 2017) can purchase coverage. Qualified individuals with income levels between 100 and 400 percent of the FPL are eligible for a federal subsidy (in the form of a refundable tax credit) to offset some of the premium cost. Operation of the exchanges began on October 1, 2013 (open season).

States have three choices for the type of exchange that will operate in their state. They can choose to (1) create a state-run exchange, (2) partner with the federal government on a federal–state exchange (in the partnership, the federal government provides the exchange architecture and system support), or (3) allow HHS to both create and assume primary responsibility for operating the exchange in the state.[72] As of October 1, 2013, 18 states and the District of Columbia launched their own exchanges, seven states are partnering with the federal government, and 26 states are defaulting to a federally run exchange. Even if a state chooses not to create an exchange now, it retains the option to take over its federal exchange in the future.

No matter what their choice, states can influence the type of plans offered in their exchange and the consumer selection process. Although states will have the strongest oversight role in state-run and partnership exchanges, HHS hopes to work with "default" states on plan certification and oversight, consumer assistance and outreach, and streamlining eligibility determinations.

Exchanges can create bidding criteria to encourage plans to focus on quality, prices, value, and care coordination. Although several states plan to open the exchange to any qualified plan, at least five states and the District of Columbia intend to review the suitability of plans based on cost and quality. Vermont, for example, authorizes the exchange to selectively contract based on price, quality, coverage of preventive services, access, participation in health reform, and other criteria deemed appropriate by the commissioner.[73] Exchanges also could establish preferences for plans that adopt effective strategies to manage costs and deliver high-quality care; such plans could be displayed more prominently on the exchange Web site.

State Laws and Authorities That Affect Health Care and Insurance

States possess many traditional laws and powers that can influence health care delivery and the cost of care, including insurance regulations, scope-of-practice determinations, antitrust powers, and rate-setting authority.

Insurance Regulations

All states regulate health insurance, though the level of authority and capacity varies.* State regulations typically involve four activities that affect the cost and quality of the health care provided: (1) plan solvency review, (2) rate review, (3) determining whether plans incorporate "mandated benefits" established by the state, and (4) enforcing rules on contractual arrangements between plans and providers and patient access to providers. The first two activities focus on ensuring that plans are financially viable and that premiums adequately reflect costs and risks. The latter two activities involve enforcement of state mandates, some of which can significantly raise the cost of health care.

Plan solvency review is a core activity of all state insurance departments. Regulators establish reserve requirements, reinsurance rules, and other standards to insure that the plans can meet their financial requirements and claims obligations. Plan solvency review is not focused on controlling costs; rather, it focuses on ensuring that plans are financially capable of delivering the level of care promised and managing risk. As plan benefits and services expand, solvency review looks carefully at premiums to make sure they are growing appropriately to cover costs and reserve requirements.

Premium rate review is related to solvency review. Traditionally, it was designed to insure that rates and rate increases appropriately cover plan-anticipated expenses. In about half of the states, the insurance department or commission has the legal authority to approve or disapprove certain types of rate changes if they are deemed unjustifiable.[74] Rate reviews can sometimes stop large increases that appear unwarranted. In the past several years, some states have been examining the provider contract prices negotiated with insurers that sharply raise premiums. If the plans or providers cannot justify the contractual prices for medical services, then the states sometimes have denied the insurance premium increase.

A recent study found that the rigor and thoroughness of state rate reviews differ widely depending on motivation, resources, and staff capacity. Standards for rate review and approval are often subjective, and many states lack the capacity to conduct indepth review.[75] However, as many states strengthen their review process as required by the ACA, more states may use the review as a means to examine the reasonableness of certain medical costs.

Insurance departments also enforce *state-mandated benefits,* which can require insurers to cover particular treatments (such as in vitro fertilization), reimburse particular providers (such as chiropractors, acupuncturists, nurse midwives, occupational therapists, and social workers), and include certain categories of dependents (such as children placed for adoption). More than half of states have 40 or more mandates on their books, and several have more than 60.[76] Although most mandates add little to insurance premiums, some can add as much as 5 percent depending on how the rule is written.[77] Several policymakers have argued that many state mandates do not reflect evidenced-based medicine or current best practices.

At least 30 states have established review procedures to assess the costs of adding new mandates. In addition, the ACA requires that states pay for the cost of any new mandate that exceeds the Essential Health Benefits (EHB) package covering plans starting in 2014

*Note that the Employee Retirement Income Security Act of 1974 (ERISA) exempts private employer "self-funded" insurance plans from state insurance law or jurisdiction. In these self-funded plans, the employer keeps the risk to pay the bills and usually hires a plan administrator to process the claims, but if an employer purchases commercial health coverage from an insurance company and the insurance company assumes the risk for payment of claims, then the insurance company is regulated under state law.

Essential Health Benefits and State-Mandated Benefits

The Patient Protection and Affordable Care Act requires that health insurance plans sold to individuals and small businesses provide a minimum package of services in 10 categories, called essential health benefits (EHB):

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness and chronic disease management
- Pediatric services, including oral and vision care

In determining how to devise the EHB package, the U.S. Department of Health and Human Services (HHS) requested recommendations from the Institute of Medicine (IOM). The IOM committee concluded that state mandates are not typically subjected to a rigorous evidence-based review or cost analysis; consequently, they should not be automatically included in the EHB package without being subject to the same medical effectiveness review process and criteria as other benefits. However—at least temporarily—HHS disregarded the IOM recommendations and let each state set its own definition of essential benefits for 2014 and 2015 by choosing a benchmark plan. States could choose from several options, including one of the three largest small-group plans or one of three largest state employee plans. As a result, because most state benefits are included in the state benchmark plan, they became part of the current EHB package in each state. HHS has indicated that this overall approach may change in 2016 and in future years.

(see sidebar, "Essential Health Benefits and State-Mandated Benefits"). However, HHS regulations allowed current state mandates to be incorporated into the EHB package of most states for 2014 and 2015 despite a report from the IOM that found that most state mandates lacked rigorous evidence-based review.[78] Many policymakers, employers, and insurers hope that inclusion of state-mandated benefits will be reconsidered by 2016, when HHS plans to review the EHB rule, and that only benefits supported by strong evidence of medical effectiveness will be included in the EHB package (see sidebar, "Essential Health Benefits and State-Mandated Benefits").[79]

Finally, insurance departments enforce *contractual rules* between plans and providers

and on *consumer access to providers.* Many of these rules can increase health care costs. For example, "any willing provider" laws in 22 states require health plans to allow any provider to participate in the plan network if it agrees to accept the plan's contract terms and payment rates.[80] Such laws can hamper the ability of health plans to create closed or tiered networks of the highest-quality providers who are equally invested in practicing efficient care. Similarly, "freedom of choice" laws in 23 states limit managed care networks from channeling patients toward in-network physicians and hospitals that provide care at lower costs. Rules such as these, frequently arising from the managed care backlash of the 1980s, can make it difficult for providers to organize more efficient care systems.

Scope of Practice

Scope-of-practice rules define the clinical care health professionals can and cannot administer to a patient and whether they can prescribe medicine, sign charts or death certificates, and independently practice, among other activities. Scope-of-practice rules can also set reimbursement procedures, such as requiring nonphysicians to submit claims through physicians. Scope of practice is defined by state boards of medicine, boards of nursing, and other professional and nonprofessional medical boards, often codified by law or procedure established by the state legislature.

Experience has shown that nonphysician providers, such as nurses, nurse practitioners, and physician assistants (PAs), can provide much of the routine and primary care frequently provided by physicians at the same level competency. Moreover, the cost of care delivered is frequently lower.

In 2010, the IOM examined scope of practice as it relates to nursing.[81] With more than 3 million members, the nursing profession is the largest segment of the nation's health care workforce. At the time, the report found that regulations defining scope-of-practice vary widely by state. Some are highly detailed, while others contain vague provisions that are open to interpretation. A major finding was that most states did not allow nurse practitioners to see patients and prescribe medications without a physician's supervision or collaboration (a 2012 survey found that only 17 states gave nurse practitioners the authority to independently prescribe medication and diagnose, treat, and refer patients).[82] The report offered the following recommendations for states:

- Reform scope-of-practice regulations to conform with the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules (Article XVIII, Chapter 18).
- Require third-party payers to provide direct reimbursement to advanced practice registered nurses who are practicing within their scope of practice under state law.

Health care coverage will grow significantly over the next decade, exacerbating the current shortage of physician primary care providers (PCPs; see Appendix on insurance expansion). To help expand the supply of PCPs and contain the growth in health care costs,

states have been reforming their scope-of-practice rules not just for nursing but for nonphysicians in other professions, including dentistry, mental health, and physical therapy. Generally, the changes allow nonphysician providers to practice at levels that reflect their competencies and training and increase their ability to practice independently (without physician supervision). Between January 2011 and December 2012, 1,795 scope-of-practice–related bills were proposed in 54 states, territories, and the District of Columbia. Of these, 349 were adopted or enacted into law.[83]

Rate-Setting Authority

States, if they are so inclined, can set rates for hospitals and other providers. For more than two decades, Maryland has regulated its hospital costs by setting state-approved rates for particular episodes of care. All payers in the state are charged the same rates set for individual hospitals, which eliminates billing disparities across plans that use the same providers. The cost-control system also includes bundled payments and pay-for-performance incentives for certain clinical categories. The Maryland Health Services Cost Review Commission, which sets the rates, has negotiated a waiver to require Medicare to pay the same state-approved rates. As a result of these efforts, the growth rate of the cost of a Maryland hospital admission has remained below the national average since 1980.[84]

State control of hospital rates is not new. As late as 1980, more than 30 states employed some form of hospital rate setting, but as a result of several factors—including the initial success of managed care in controlling price growth—rate-setting fell into disfavor. Only Maryland and West Virginia set rates today.[85] Furthermore, Congress is highly unlikely to increase Medicare fee-for-service rates as occurred in Maryland as a condition for it being able to adopt all-payer pricing.

Medical Malpractice[86]

Most providers, as well as many consumers and policymakers, assert that today's malpractice system is broken. This claim has persisted almost since medicine became a profession. As early as 1850, the Massachusetts Medical Society referred to the "alarmingly frequent" malpractice cases and suggested that they caused some surgeons to leave the practice of medicine.[87] Today, as much as 75 percent of low-risk specialty physicians and 99 percent of high-risk specialty physicians face a malpractice claim by 65 years of age.[88]

Patients who suffer injury while receiving care are unhappy with the current process for resolving claims. Plaintiffs who prevail in court often wait years before receiving compensation and—because the current legal system requires a great deal of time, effort, and money to determine fault—are encouraged to seek large damages. Conversely, few opportunities exist to quickly resolve minor errors with appropriate compensation.

Malpractice cases have both direct and indirect costs. Direct costs include the cost of insurance premiums and legal expenses. In 2009, the CBO estimated the direct cost of malpractice to be $25 billion.[89] The indirect costs are more difficult to quantify, because

they include the cost of *defensive medicine*—additional procedures or tests physicians may administer in response to the threat of malpractice. A 2003 report by HHS estimates that indirect cost may total between $70 billion and $126 billion annually, while another 2008 study estimated that indirect costs total $45.6 billion.[90,91]

For the past decade, states have been changing their medical malpractice laws to reduce malpractice insurance premiums and the cost of defensive medicine. Changes have focused on several key areas, including:[92]

- **Limiting damage awards.** Thirty-eight jurisdictions (states, territories, and the District of Columbia) have limits.
- **Limits on attorney fees.** Twenty-eights states have provisions that place limitations on attorneys' fees.
- **Pretrial alternative dispute resolution and screening panels.** Twenty-seven states, the District of Columbia, Guam, and Puerto Rico have specific provisions providing for alternative dispute resolution (arbitration, mediation, or settlement conferences) in medical liability or malpractice cases.
- **Expert witness standards.** Thirty-one states have provisions regarding minimum qualifications for expert witnesses who testify in medical malpractice or liability cases.
- **Medical or peer review panels.** All but three jurisdictions—New Mexico, New York, and Puerto Rico—have provisions regarding medical or peer review panels.
- **Safe harbor laws.** These laws theoretically provide physicians with a "safe harbor" from lawsuit if they can demonstrate that they adhered to clinical best practice guidelines. Maine, Florida, Kentucky, Vermont, and Minnesota experimented with demonstration projects of safe harbors in the 1990s, but little was learned from them because the demonstrations were narrow in scope, operated for only a few years, and were not evaluated for their effect on malpractice litigation.

Other reform options are being considered, as well:

- **Health courts.** In this system, claims are routed to a subset of judges who have received special training and are assisted by neutral court attorneys who also have health care degrees, such as nursing degrees.[93] These judges would encourage early settlements and avoid large jury verdicts, which account for the worst excesses in the current system. It would also avoid long delays in compensation. No state has fully adopted this model.
- **Disclosure and offer.** This approach has been used by the University of Michigan Health System (UMHS), which created the model. In this approach, a liability insurer and its insured institutions proactively disclose unanticipated adverse outcomes to patients, perform an expedited investigation, provide a full explanation, offer an apology, make a rapid offer of compensation (conditioned upon a release of liability), and pursue clinical–process improvements to prevent recurrence of the event.[94] UMHS found that this approach led to fewer claims, fewer lawsuits, and lower liability costs. It does not necessarily require state action to implement.

- **Administrative compensation.** This approach takes medical malpractice out of the standard courts and treats it much like current workers' compensation systems. Plaintiffs filing a claim would not have to prove that their providers were negligent, only that their injury could have been avoided in an optimal system of care. Such a system would avoid assigning blame on the provider and would provide fixed rates of compensation. Most proposals would finance the system through annual provider fees. The need for malpractice insurance would, in theory, be eliminated. No state has adopted this model.

Despite enactment of reforms in many states, the effect on so-called "defensive medicine" is thought to be limited.[95] A recent study determined that traditional malpractice reforms do not significantly reduce defensive medicine, because most defensive medicine is motivated by the provider's *perceived* risk.[96] Thus, reforms that focus on standards of care, nonjury-based compensation systems, compensation schedules, communication between physicians and patients about why adverse outcomes occur, and provider education on the reforms may have the best chance for success. Many consumers feel that such systems are more fair because they reduce delays and avoid litigation.

Laws and Authorities That Affect Competition and Transparency

States have the ability to address noncompetitive practices that affect prices and increase the transparency around health care costs and quality. One lever involves the use of state antitrust powers; the other involves the authority to collect, analyze, and publish information on medical costs and quality from providers throughout the state.

Antitrust Powers

States have their own antitrust authority and can bring antitrust suits in federal court. In health care, antitrust has been used to address instances of anticompetitive behavior and market dominance arising from consolidation of health care providers and hospitals (see Chapter 1 for a discussion of provider consolidation and market power).

Several health care provider consolidations over the past few years have been scrutinized or challenged for their antitrust implications. In most cases, the federal government (the Federal Trade Commission and U.S. Department of Justice) has led these investigations, with states often joining as partners. Some challenges have resulted in the providers abandoning the proposed deal, the requirement of divestitures, or the imposition of conduct restrictions.[97]

Antitrust action can be a useful tool for addressing price growth arising from market consolidation, but such cases are complicated and often represent a last-choice option for several reasons. For one, states and the federal government are encouraging consolidation in the hopes that it will improve the efficiency and quality of care. Many states even are

giving providers a "safe harbor" to collaborate. Second, adverse market effects often are not realized until mergers or acquisitions are complete. Remedies to dismantle such consolidation can be difficult and time-consuming to pursue. Third, all antitrust investigations are resource intensive. The federal government has the resources to pursue only a limited number of cases each year; state resources are vastly more limited. Fourth, plaintiffs need detailed data on provider claims throughout the state to identify potential noncompetitive behaviors and successfully make the case. Only a limited number of states collect such data now, so most cases must retroactively collect the information, which can be time-consuming. Finally, many antitrust actions end up failing or are dismissed by the time they go to trial after months or years of investigation and litigation. Thus, states should pursue antitrust action only in the most egregious circumstances and if all other options for controlling health care costs have failed.

Transparency and Data Collection

Transparency—information on medical costs, spending trends, and quality—can be a powerful tool that helps policymakers and the public understand the reasons behind health care cost growth and how to curb it. In addition, precise information on provider costs and quality can help consumers choose the best value when seeking medical services. States play an important role in making medical cost and quality data available to the public and policymakers.

To obtain the detailed data needed to monitor health spending trends, charges, and utilization, states must seek information from insurers, plan administrators, and managers of government health programs—a complex undertaking for all involved. One approach is to create an all-payer claims database (APCD), which gives the state the authority and capacity to collect and analyze claims data. Fourteen states have created APCDs, and all are in various stages of implementation.[98] These comprehensive systems collect and analyze medical, pharmacy, diagnostic, and dental claims from a variety of public and private sources, including insurance carriers, third-party administrators, pharmacy benefit managers, state Medicaid agencies, and Medicare. A fully functioning APCD can provide:

- Information on total payments and utilization for selected procedures by provider (hospitals, labs, and clinicians) and payers
- Benchmark information on utilization rates and costs for specific procedures, which can be used to identify cost drivers
- Data on regional differences in cost and utilization within the state
- Trends in the costs and utilization of specific procedures by specific providers over time

Despite its utility, establishing and operating an APCD can be expensive, and annual funding is needed to maintain operations. Alternatively, states can attempt to establish voluntary arrangements with their largest in-state insurers to obtain similar data, but the information still requires analysis. A third option may soon may be available, however:

The Health Care Cost Institute

The Health Care Cost Institute (HCCI; www.healthcostinstitute.org) is an example of a voluntary effort to collect claims data from commercial and public plans nationwide. An independent, nonprofit entity promoting research on the drivers of escalating health care costs and utilization in the United States, HCCI collects comprehensive information on health care spending and utilization trends and maintains an exclusive centralized database of public- and private-sector health care data. At its launch, the database covered 5 billion medical claims and $1 trillion in health care activity from 2001 to the present, including $200 billion in 2010 alone. The database includes 5,000 hospitals and more than 1 million medical service providers from commercial health plans operated by Aetna, Humana, Kaiser Permanente, and UnitedHealthcare. Within the next 2 years, HCCI expects to receive both Medicare and Medicaid claims data, dramatically increasing the population of insurance claims that the database covers. The HCCI data are available to accredited researchers whose proposals meet HCCI's data and scientific usage standards. The Institute will also conduct indepth analysis and projections on cost trends that inform public- and private-sector efforts to reduce health care costs while improving the quality and availability of coverage. HCCI recently entered into a 3 year partnership with the Vermont Department of Financial Regulation and the Green Mountain Care Board that will advance and improve public reporting on health care in Vermont and the nation.

The Health Care Cost Institute (HCCI) is a nonprofit organization that collects claims data from the largest national health plans (see sidebar, "The Health Care Cost Institute). Over time, the HCCI hopes to collect both private and government claims data on all major plans, including those using global budgets, and provide the information to researchers and policymakers at a reasonable cost.

It is important to note that most claims data today are based on the fee-for-service model. As health care delivery systems become more integrated and financed through global prepayments, detailed information on the cost and utilization of specific medical services will be needed from health plans that operate under global budgets. Such data are available but may not be in the claims data. The HCCI is developing procedures to obtain the type of information needed.

State efforts to analyze health care cost and quality data can help policymakers and the public understand health care spending trends, payment rates, and utilization throughout the state. Transparency can shine a light on the highest-cost providers, identify disparities in charges, and help create data-driven policies to better manage cost growth. As part of Massachusetts's plans to control rising health care costs, the state attorneys general have published several annual reports examining health care cost trends and drivers in the state.

These reports identify price disparities among providers, the reasons for such disparities, and progress in meeting state cost control goals.

Although efforts to collect statewide data on the costs and quality of health care are proving useful to policymakers, the information may not be specific or personal enough to influence how consumers choose providers. Most state efforts to inform consumers on medical costs are in their infancy, and the utility of the information is mixed. A recent study reviewed the transparency initiatives in each state and graded them on whether they provided the necessary quality and price information to help consumers make informed decisions about where to seek health care.[99] Only two states—Massachusetts and New Hampshire—received an "A" rating, while just five states received a "B" rating. Eighteen states received an "F," but even in states that received the highest grades, accessing and understanding the data quickly and easily remain daunting for all but the most sophisticated consumer.

As indicated in Chapter 1, cost data for consumers must be accompanied by strong quality signals and provide information specific to the individual's health plan, such as his or her share of spending, to influence treatment choices. States can help consumers see broad trends in provider charges and quality across all plans, but only individual plans can provide the type of precise information consumers need when choosing the best-value, highest-quality care.

Public Initiatives to Promote Population Health

For almost two centuries, states have been at the forefront of efforts to improve population health. From the earliest quarantine and sanitation laws to more modern initiatives around vaccinations, tobacco cessation, drug abuse, and mental health, states have supported interventions to improve their citizens' quality of life. More recently, in response to growing concerns over the obesity epidemic—particularly in children—states have been adopting policies to promote access to healthy foods, improve the physical environment for recreation, and encourage exercise and better nutrition.[100]

Obesity presents a major population health dilemma and is a key factor behind our rising health care spending. One study estimated that if the average body mass index (BMI) were reduced by just 5 percent, total health care costs could fall by between 6.5 percent and 7.9 percent in nearly every state.[101] Unfortunately, America's youth are growing up less healthy than their parents, potentially creating a burden on themselves, their families, and their community.

Interventions that states have taken to control the growing obesity epidemic fall into three categories:

- **School-based policies.** These policies include setting nutrition standards for school meals, limiting unhealthy food and drinks in school vending machines, conducting

fitness screenings and preparing confidential BMI reports for parents, providing nutrition education, hosting noninvasive diabetes screenings, and setting standards on physical activity or physical education in school.

- **Healthy community design.** These policies include state grant programs to expand bicycling and walking paths, encourage transit-oriented development, and create safe bicycle and walking routes to schools.
- **Increasing community access to healthy foods.** These programs include financial assistance for construction and support of farmers' markets, providing these markets with financial assistance to process electronic benefits transfer cards so they can accept food stamp payments, and providing loans and grants to grocery stores located in underserved communities.

Virtually every state has launched at least one intervention to reduce obesity and promote healthy living. Although more research is needed to understand the effectiveness of these interventions, studies have already identified several strategies that work, particularly for children. For example, one study reviewed 51 programs that have been evaluated for their impacts on nutrition, physical activity, or weight loss.[102] Although not all programs were successful, the study found that:

- Most of the programs that targeted overweight or obese children had impacts on at least one outcome. Six out of eight nutrition programs, five out of seven physical activity programs, and nine out of 15 weight loss programs were effective.
- Programs with narrower goals were generally more successful in achieving the specific desired behavioral improvements. Eight out of the 15 programs that focused solely on nutrition, on physical activity, or on weight loss demonstrated an impact on the targeted outcome.
- Programs that implement a therapy/counseling component can be successful at improving child and adolescent nutrition and physical activity. All four programs that provided therapy sessions for participants and their families were successful at improving nutrition outcomes, and three of four programs were successful at improving physical activity.

Other meta-analyses have examined interventions to increase healthy activity in the community. One study found that:[103]

> *"Living in walkable communities and having parks and other recreation facilities nearby were consistently associated with higher levels of physical activity in youth, adults, and older adults. Better school design, such as including basketball hoops and having a large school grounds, and better building design, such as signs promoting stair use and more convenient access to stairs than to elevators were associated with higher levels of physical activity in youth, adults and older adults."*

More work is needed to identify the most effective strategies, but research to date suggests that state policies to control obesity and promote healthier communities can be an important component of efforts to control health spending and improve health outcomes.

Engaging Stakeholders and Creating a Process for Change

States play a major role in engaging stakeholders and creating a framework to solve public policy issues. For many decades, governors and legislatures have created temporary and permanent commissions or informal working groups to address their state's most pressing problems. In doing so, the state has brought together members of the private sector, public, advocacy community, and academia along with appropriate government officials to reach consensus and tackle such issues as education reform, crime and public safety, state fiscal priorities and budget reduction options, health care coverage for children, public health, infrastructure investment, natural disasters and emergency management, and economic development.

In much the same way, governors and legislatures can use their influence to engage stakeholders and work with them to confront the problem of rising health care costs—not just for public programs like Medicaid, but for all payers and consumers. It is an ambitious but worthy undertaking.

In 2011, Washington Governor Christine Gregoire asked a group of business, nonprofit, and government leaders to identify approaches for making health care more cost-effective and efficient in the state. Although several options were discussed, the state recognized that a long-term effort would be needed to identify and implement cost-saving practices, but they knew that it was important to begin with a goal. The goal they established was to hold the annual growth rate of health care spending in the state to between 4 percent and 5 percent by 2014, which would reduce total spending by $26 billion over 10 years. This goal is intended to guide the future efforts of purchasers, providers, and other stakeholders as they seek solutions.

More recently, Massachusetts took a comprehensive approach to the issue and established a permanent process for tracking and controlling health care costs in the commonwealth.[104] Since the 1990s, Massachusetts has been searching for ways to control its swiftly rising health care costs. The state has high rates of health care coverage, and the health care industry is extremely robust. Per-capita health spending is 15 percent higher than the national average, and the commonwealth has the highest individual market premiums in the country.[105]

The 2012 cost-control law that the commonwealth enacted involved input from major stakeholders—hospitals, insurers, physicians, and consumer advocates. The bill sets annual state spending targets, encourages the formation of ACOs, and establishes an independent commission to oversee health care system performance. A newly established Health

Policy Commission, which includes an 11-member provider-based advisory committee, will monitor health spending, set cost growth benchmarks, and track the activities of providers and payers.

Washington and Massachusetts are just two examples of states beginning a process to improve the cost-effectiveness and value of health care for all payers, both public and private. In particular, the ambitiousness of the Massachusetts plan demonstrates how significant the issue of health care spending has become to the constituents of that commonwealth. As other states develop their own approaches to address health care costs, common strategies will be needed, including a process for engaging stakeholders, procedures to collect and monitor health cost data, a process for defining and setting cost growth targets, and the identification of possible mechanisms to ensure that goals eventually are met.

The Governor's Bully Pulpit

Creating change in a state often begins with the governor and his or her use of the "bully pulpit." Governors can use the bully pulpit formally and informally to focus public attention on a specific issue, communicate concerns, and shape public opinion. Formal tools include official communications such as the state-of-the-state message, the budget message, and official testimony before the state legislature. Less formal tools include meetings with key stakeholders, press conferences and press releases, appearances and speeches, the governor's Web site, and correspondence and constituent services.[106] The governor can also ask the lieutenant governor or cabinet and agency officials to speak out on the issue, thus expanding the reach of the message.

Using the bully pulpit to focus public attention on the high cost of health care should garner widespread political support in most states. Above all else, health care has become a "pocketbook" issue affecting everyone—government, businesses, and consumers. The governor often can help marshal and shape the public and political will to take action to solve the problem. The bully pulpit can also sustain action by communicating progress after efforts have begun. By creating a consensus and commitment for change and coordinating action across all stakeholders, gubernatorial leadership can drive change, often through voluntary efforts in lieu of regulations.

4. Commission Recommendations and Action Plan

The Commission believes that American health care can and should be:

- Affordable
- Coordinated, patient centered, and evidence based
- Financially motivated to control costs and promote quality

To achieve this vision, providers, including hospitals and outpatient services, must be coaxed to organize into entities or partnerships that deliver integrated and coordinated care, use health care data to inform treatment decisions, and use financial incentives to reward quality and cost control. To ensure accountability, health care organizations must also bear a financial risk if they *fail to attain* quality and cost-management expectations. For this reason, the Commission believes that health care must increasingly move toward risk-based payments covering comprehensive services. Although payments for individual services will always play some role in our health care system, the reliance on fee-for-service must be lowered.

This goal is attainable, but it will take state leadership to reach it, with governors playing a critical role. Although the transition will take years, states can achieve meaningful reforms if they can garner the support of payers, providers, insurers, and consumers. As the nation's "laboratories of democracy," states can be a proving ground for new approaches that raise the efficiency and value of health care.

This chapter presents the Commissioners' action plan and recommendations. The overall strategy uses the state levers identified in Chapter 3 to address the problems identified in the introduction. This approach will require significant capacity building and reorganization within the current delivery system. States will need some type of institutional structure to guide the transformation over time and report progress. They will need to set a goal for health care spending in the state and analyze the reasons behind cost growth. They will need to use their purchasing power to encourage formation of risk-based, coordinated care entities, and they will need to rationalize state health regulations to remove obstacles to greater efficiency. Most of all, they will need payers and stakeholders to join their efforts in reaching a common vision for health care.

The Commissioners recommend that states apply the following strategies:

- Create an alliance of stakeholders to transform the health care system.
- Define and collect data to create a profile of health care in the state.
- Establish statewide baselines and goals for health care spending, quality, and other measures as appropriate.
- Use existing health care programs to accelerate the trend toward coordinated care using risk-based payments.
- Encourage market competition and consumer selection of high-value care based on cost and quality data.
- Reform health care regulations to promote system efficiency.
- Help citizens make better lifestyle choices and promote personal responsibility in health care.

Recommendation 1: Create an Alliance of Stakeholders to Transform the Health Care System

The first step in transforming the health care system is to create an alliance among government and stakeholders to improve both the quality and the cost-efficiency of services. Changing how health care is delivered is a gradual and evolving process that can take many years. The state can facilitate this transition and provide institutional support, but it cannot succeed without the long-term commitment of stakeholders, including payers, consumers, and providers.

A state alliance for transforming health care delivery can take several forms, largely influenced by the culture in the state. Some states may be able to effect change through temporary commissions, advisory groups, and voluntary efforts. Others may require more permanent and formal institutional structures and enabling legislation or executive orders. Whatever approach the state chooses, it must be prepared to lead and support certain critical actions, including creating a strategic plan, establishing goals for improving quality and curbing spending, and monitoring progress.

Most states will need to establish at least a temporary commission to engage their stakeholders and begin work. In choosing members of the health care commission or alliance, states should consider individuals from the following groups or disciplines to serve as either members or advisors:

- Legislative leaders
- The insurance commissioner
- The Medicaid director and public health officials
- Business leaders and large ERISA employee health care purchasers
- Health plan issuers
- Providers, both physicians and nonphysicians, and provider groups
- Hospitals

- Health care consumers
- Individuals who understand the federal Medicare program
- Operators of electronic health care records exchanges
- Experts in evolving trends in medical care and training

The governor should chair the health care commission. Because transforming the health care system likely will span the terms of several governors and legislatures, some states may find it useful to create a permanent body of state officials and stakeholders to oversee progress. States will also need to support several key activities over the years that will be crucial for long-run monitoring and control of health care spending:

- Collect and analyze medical spending data, and track spending on an annual basis.
- Establish annual goals for health care quality and spending growth rates.
- Establish criteria to define high-performing coordinated care organizations that accept risk-based payments.
- Report annually on the cost of health care and compliance with cost-control targets.
- Review and establish policies in such areas as insurance regulations, scope of practice, medical malpractice, and data transparency.
- Identify and implement levers and incentives for cost control.

Recommendation 2: Define and Collect Data to Create a Profile of Health Care in the State

Working with their stakeholder alliance, states should establish a common definition of health care spending, identify quality measures to track, create a process for collecting cost and quality data, and conduct an initial analysis of where health care spending is concentrated. The state should also conduct an inventory of health plans, providers, and delivery systems.

Action 2–1. Define Health Care Spending

States should create a common measure of health care spending that allows identification of a baseline and permits year-to-year tracking of spending growth. Although individual states may choose to include slightly different items in their measure, the Commissioners recommend that each state focus on per-capita health care costs using the following basic formula:

Annual per-capita health care costs = total state medical costs/population of state

Within this formula, the term *total state medical costs* consists of:

- The total expenditures for medical care delivered to state residents through Medicare, Medicaid, other public plans (e.g., TRICARE and workers' compensation), private insurance, and ERISA plans

- Pharmacy costs
- Co-pays and co-insurance spending
- The net cost of insurance premiums (i.e., premium expenses in excess of medical spending for benefits provided)

This definition of *spending* is similar to one measure the federal government uses to track national spending. Other components that states may want to include in total state medical costs are medical equipment purchased, public health expenditures, facility investments, and medical research costs.

Action 2–2. Collect Detailed Data on Health Spending Throughout the State

Medical claims data will serve as the primary source for detailed information on the cost of health care services. This information should be used to establish an initial baseline; analyze changes and trends on a yearly basis; and provide information on costs among providers, services, and regions. The claims data must be sufficiently detailed to provide the following information:

- Spending by service category, such as in-patient and out-patient care, pharmacy costs, home health care, dental services, imaging, and durable equipment (Such information should be reported as a state total, by geographic region, and by provider network and hospital.)
- Costs for common treatments by geographic region, provider group, and hospital
- Costs per patient for capitated medical plans by region and provider network

Most states will need to establish some type of independent body to oversee or implement gathering medical claims data and subsequent analysis. States that have created APCDs—10 are fully operating—already have some of these capabilities, though most would need to expand their sources of claims data beyond private insurers. Claims data must encompass all private and public plans in the state, including Medicare, Medicaid, third-party administrators, and commercial and private insurers.

The creation or expansion of a state-run APCD may not be the only option for collecting and analyzing claims information. At least one independent organization—the HCCI (see Chapter 3)—is already collecting data from large commercial insurers and third-party administrators and plans to include both Medicaid and Medicare data in the future. The HCCI plans to share these data with other researchers and is attempting to expand the number of private plans contributing to its records. As the HCCI's or similar data-collection efforts grow, states may be able to contract with these organizations to collect and analyze the data in their state. Even in these cases, however, a small technical group representing the state still will be needed to oversee the work. Moreover, non-APCD states may need to pass laws to allow collection of the data and to establish guidelines on their use, even if processed by third parties.

Action 2–3. Conduct an Initial Comparative Analysis and Determine Subcomponents of Health Care Spending

The state should calculate baseline spending for various subcomponents of state health care. The state should also calculate and compare with the national average (1) the average per-capita cost of specific procedures and services at different hospitals and provider organizations within the state and (2) the average total cost of care per person for each major health plan. Finally, regional and provider-level costs should be compared with state averages to determine the range of variability and identify outliers. States may find that certain procedures vary in cost by 100 percent or more across providers and between different areas of the state. States can use such analysis to focus on certain services, regions, or provider organizations when developing cost-management strategies.

Action 2–4. Define and Collect Data on the Quality of Health Care Delivery

The state should identify a set of quality measures that all health care organizations in the state must consistently report. The Commissioners recommend that states begin by reviewing the 33 quality measures that HHS requires for ACOs and supplement them as desired. Because the HHS developed the ACO quality measures for the Medicare population, some may not be suitable for organizations serving the general population. HHS has also published core sets of measures for children, adults, and other populations, and the National Quality Forum (NQF) provides information on NQF-endorsed measures. States can consult these sources to identify other quality measures of performance.

The 33 quality performance measures that HHS recommends for Medicare ACOs cover four domains:

- Patient/caregiver experience (seven measures)
- Care coordination/patient safety (six measures)
- Preventive health (eight measures)
- At-risk population:
  - — Diabetes (one measure and one composite consisting of five measures)
  - — Hypertension (one measure)
  - — Ischemic vascular disease (two measures)
  - — Heart failure (one measure)
  - — Coronary artery disease (one composite consisting of two measures)

Each measure provides information on the quality of care delivered. For example, one measure asks providers to report the percentage of diabetic patients 18–75 years of age who have low-density lipoprotein cholesterol levels below 100 mg/dL—a primary goal of diabetes treatment for most patients. A high-performing health system should be able to show steady improvement in this measure each year.

States should require health care organizations to focus on collecting and reporting quality data for the first 1–2 years of implementation before judging plan performance.

After a firm baseline has been set, the state can establish annual benchmarks and begin rating plans on overall performance (see Action 3–2).

Action 2–5. Collect Data on Key Population Health Statistics and Factors That Affect Population Health

Most states have already established a process to gather, analyze, and report trends in key population health statistics, such as death rates (including infant mortality), cancer, heart disease, obesity, diabetes, alcohol and tobacco use, and immunization status. Such data are often broken down by race, gender, and geographic location and can be used to identify the health of the overall population as well as potential problems within certain regions or populations. Collecting and tracking such data should be part of any state strategy to manage health care costs and improve health care quality.

For example, in 2012, the governor of California published the "Let's Get Healthy California Task Force Report,"[107] which provides a framework for assessing Californians' health across the lifespan, with a focus on healthy beginnings, living well, and end of life. The task force identified 39 health indicators that, taken together, could be used to paint a picture of the state's overall level of health. Ten-year targets were established for each indicator to help measure whether Californians are becoming healthier over time. The baseline indicators and their changes over time will help identify priority areas for public health and the health care system overall.

Action 2–6. Inventory the Health Care Infrastructure, Including Providers and Plans

The state should work with its alliance to conduct an inventory of the state's health care infrastructure. The inventory should identify the type and number of health care insurers and provider organizations in the state and the process by which care is delivered and compensated. Information should include:

- The number and type of providers in the state (e.g., general practice or area of specialty)
- Overall system capacity (e.g., number of hospitals and provider organizations, regional coverage of health care services, number and type of commercial plans)
- Organization of each delivery system (e.g., number of HMOs, independent practices, ACOs) and populations covered by each
- Payment models that existing health care organizations in the state use

The inventory will help determine current system robustness and whether any organizations exist that can move forward quickly and serve as models of change.

Recommendation 3: Establish Statewide Baselines and Goals for Health Care Spending, Quality, and Other Measures as Appropriate

The state and its alliance of stakeholders should establish appropriate targets for cost growth and quality improvements in the health care system. The state should annually collect timely and accurate data and report to the public and policymakers on progress toward meeting goals. Such annual reports should be used to inform the development of policies to assist in meeting the goals.

Action 3–1. Adopt Annual Spending Benchmarks for the Next Five Years

The state should establish specific goals or limits on the annual percentage increase of state per-capita health care expenditures over at least the next 5 years. The most straightforward approach is to base the target on some fraction of state economic growth.

The Commission recommends that states set a target based on the annual growth rate of the state economy as measured by the gross state product (GSP). States can choose to set the health spending target to the same growth rate as the GSP, make it lower, or set it higher depending on circumstances. For example, the recent Massachusetts law set the state benchmark at the same growth rate as the GSP for 2014 through 2017. For 2018 to 2022, the state established the rate at GSP minus 0.5 percent. (By comparison, national health care spending as described in the introduction has been rising faster than annual economic growth, as measured by GDP.)

When adopting spending growth targets for the first several years, it is important that states consider the effect of coverage expansions under the ACA and other provisions that affect total medical expenditures. These factors will increase per-capita spending.

Action 3–2. Adopt Annual Benchmark Goals on Quality for the Next Five Years

To ensure that cost management does not come at the expense of health care quality, states should establish annual benchmarks for quality improvement and overall quality performance for each measure reported under Action 2–4. For the first 1-2 years, health care organizations should accurately report each measure and its annual change but not be held to any benchmark. After baseline measures have been established, states can set goals for year-to-year improvements as well as overall performance for each measure. Doing so will allow organizations to be graded on their efforts to improve the quality of care for their enrollees as well as their ability to achieve an overall quality target.

Action 3–3. Adopt Benchmark Goals for Key Population Statistics

States should set longer-term goals for tracking improvements in population health. Although the statistics should be reported and updated annually, if possible, progress should be measured over a longer time, such as every 5 years. Changes in population health

should be used to determine the performance of the overall health care system in the state, including public health programs, but the information gleaned can be used to emphasize certain care strategies and adjust quality measures, if necessary. For example, if state diabetes rates remain unchanged or continue to grow, quality measures can be added that stress aggressive diabetes treatment and counseling. Some measures may need assistance from the state in the form of policies that promote healthy lifestyles and improve nutrition (discussed later in this chapter).

Action 3–4. Conduct an Annual Review of Spending and Quality and Report the Results

Each year, states should review the most up-to-date spending and quality data. The first year should focus on calculating a per-capita spending baseline and reporting accurate quality information. Future years should focus on progress toward meeting spending growth targets for the state and for individual components of the health care system and in meeting quality improvement goals and benchmarks.

States should create a special Web site to provide annual information to the public and media on the cost of health care in the state and compliance with spending goals. In addition to examining compliance with statewide targets, the state should compare costs in subcategories of the health care system, including differences among hospitals and provider organizations for common treatments, procedures, and drugs. State averages or median costs for such services should be identified and used as a basis for identifying cost-management performance. The Web site can also serve as a gateway to other, related information, such as statewide provider cost and quality data, the health insurance exchange, and other health care information and services.

Quality reports for each health care system in the state should be made. States should consider developing an easy-to-understand rating system to report system performance in meeting annual improvement benchmarks and overall performance.

The governor should play a central role in drawing the public's attention to these annual reports and to efforts by the state and stakeholders to improve the health care system. The state-of-the-state address and other speech opportunities should be used to inform the public of progress in achieving health system reforms and the implications for consumers and businesses.

Recommendation 4: Use Existing Health Care Programs to Accelerate the Trend Toward Patient-Centered High-Performing Care

States should use health programs they administer or oversee to move the delivery system away from one that emphasizes payment for individual services toward one that

emphasizes both high-quality care and cost management. By using their leverage as purchasers, states can push toward the patient-centered and high-performing delivery systems described in Chapter 2. This purchasing power is one of the strongest levers in the state tool kit. A host of payment models (such as shared savings, bundled, and global payments) that emphasize accountability for outcomes (such as controlling blood sugar levels in diabetic patients and reducing preventable readmissions or complications) can be applied to the unique populations and markets in each state. Programs that states can use for leverage include Medicaid, CHIP, the state employee health program (which can be combined with local government employees for increased influence), and the insurance exchanges.

Action 4–1. Create a State Definition of Coordinated, Risk-Based Care

States should create a standard definition of what constitutes a high-performing coordinated care organization that manages costs and promotes quality using risk-based payments—in essence, an expanded definition of the one for high-performing care described in Chapter 2. Such a definition would establish goals for all health care organizations in the state and allow payers to identify plans that deliver the best care and value. Some states may want to establish a process to formally designate organizations that meet the state definition.

The Commissioners recommend that the state definition of coordinated, risk-based care address each of the following elements:*

- **Care coordination expertise.** Organizations should demonstrate that they possess adequate primary care resources, including personnel, and the capability to coordinate care for individual patients across all treatment settings.
- **Capability to use health IT to support patient care.** Organizations should demonstrate that they can meet expectations on the use of EHRs and data sharing to support patient care.
- **Patient-centricity.** Quality measures should include patient satisfaction indicators. The indicators should demonstrate a high degree of patient satisfaction with understanding the care needs of the "whole person," care coordination and communication, patient support and empowerment, and ready access to care.[108]
- **Capability to deliver the full scope of services required to provide total-population health management.** Organizations should demonstrate that they are capable of providing the full range of health care needs for the population covered.
- **Ability to demonstrate commitment to and achievement of high-quality health care and cost management using risk-based payments.** Organizations should demonstrate that they can measure and track all required quality metrics and employ risk-based

*Different criteria under each element may be needed for plans that cover distinct populations. For example, risk-based coordinated care plans covering long-term care services may need different criteria than those used for risk-based, coordinated care plans covering healthy children and adults.

What "Risk-Based Payments" Means in This Report

For the purposes of this report, risk-based payments refers to compensation systems that:

- Require that health care organizations assume the risk of providing care at a guaranteed rate determined through negotiation between the provider and payer
- Encourage providers within the organization to be held accountable for managing costs and delivering high-quality care through "shared savings" arrangements

For a coordinated care organization delivering comprehensive services as described under Action 4–1, a risk-based payment would take the form of a per-person fee covering all health care services needed for a fixed period, such as monthly or yearly (this would also be considered a global payment). If the organization delivers all care needed at the quality level expected but at a cost lower than the established fee, then the organization retains the savings and must share it among all providers who meet cost and quality performance goals (shared savings). If care costs exceed the fee, then the organization assumes the risk for the additional expenses and must use reserves to cover them.

For organizations that do not provide comprehensive care services, such as hospitals that are not part of a hospital–physician health system, risk-based payments may take the form of a bundled payment. Episode or bundled payments are single payments for a group of services related to a treatment or condition that may involve multiple providers across multiple settings. In this case, the team of providers may share savings if actual costs are less than the bundled payment and the care meets established quality goals.

payments that encourage providers to improve quality and manage costs (see sidebar, "What 'Risk-Based Payments' Means in This Report").

- **Risk-bearing capability.** Organizations should be able to demonstrate that they have the financial resources to use risk-based payments and meet the care demands of the covered population.

States do not have to craft their standards in a vacuum. They can start by considering the criteria that HHS and the nonprofit National Committee for Quality Assurance (NCQA) developed for certifying and accrediting ACOs.[109] They can also look at the core measures and state-specific measures being developed for the Medicare and Medicaid financial alignment demonstrations. These criteria can be useful in defining the structure of coordinated, risk-based care organizations; their capabilities; and the type of quality measures they should report. They do not, however, elaborate on risk-based payment arrangements. States will need to specify acceptable types of risk-based payment options, which might include payments that (1) are based on a global budget, (2) allow the organization to retain savings incurred by spending less than the global budget, and (3) include a system that rewards providers—not just plans—for meeting cost and quality goals. State

oversight should ensure that excessive risk is not shifted to providers that lack sufficient financial resources or managerial expertise and that risk-adjustment mechanisms exist to mitigate any tendency to avoid populations with greater medical needs.

Organizations that meet the state definition of *coordinated, risk-based care* should undergo a yearly performance review. For example, start-up organizations that meet the state criteria but have not yet produced sufficient data to measure compliance with cost and quality goals may be assigned a "provisional" status. After an organization has been operating for at least a year, the state could begin assigning scores based on the results in meeting each goal. Health care systems could be ranked or graded based on how well they score in each category. Those that score above a certain level in both quality and cost management could be given a "high-performing" designation.

Action 4–2. Transition Medicaid for Children and Adults Toward Patient-Centered, High-Performing Care

Several states, such as Colorado and Oregon, are making major strides in incorporating high-value care into their Medicaid purchasing, and most states report some movement along these lines. For example, Colorado recently reported that its year-old ACO program returned $3 million in state savings in its first year, and Utah is launching a new managed care program for most Medicaid beneficiaries with a strong ACO component.[110]

States should increasingly merge the elements of a patient-centered, high-performing health care system into their contracts with the Medicaid MCOs and providers who serve the 74 percent of enrollees already in some type of coordinated care. States should also extend the elements of high-performing systems into additional geographic regions—usually rural counties—that still rely on pure fee-for-service payments. The ease of transition will depend on such factors as population, availability and type of providers, and extent to which integrated systems already exist. States will need to be flexible in adapting to local circumstances but should not settle for the status quo. Critically, states must use their purchasing power to shape payment arrangements so that providers are rewarded for both efficiency and quality to achieve the desired system transformation.

Action 4–3. Work with Plans and Providers to Create the Capacity to Provide Coordinated, Risk-Based Care to the Disabled and Dual-Eligible Population

A large portion of Medicaid disabled and elderly beneficiaries remain in fee-for-service arrangements. Most of this population, about 9 million people, also are dually eligible, which means that they qualify for both Medicaid and Medicare benefits. These individuals account for only 15 percent of state Medicaid enrollees but almost 40 percent of all Medicaid costs.[111] Care for this population is often both more expensive than necessary and of poor quality, relying excessively on in-patient hospital admissions, emergency care, and institutionalization. However, creating integrated delivery systems for this group is complicated, because the patients are covered by both Medicare and Medicaid, which have

different financial and administrative arrangements.

HHS currently funds a demonstration program to test new approaches of care coordination and payment for the dual-eligible population. Twenty-six states submitted proposals to participate in the program. Eight have been approved as of this writing, and many projects are still being negotiated with HHS. Most states have proposed using risk-based managed care models to deliver integrated Medicaid–Medicare services to dual-eligible people in these demonstrations.[112] To the greatest extent feasible, states should incorporate the elements of a patient-centered, high-performing health care system described in Chapter 2 into their contracts with MCOs participating in the demonstration. As with the non-dual population, attaching financial incentives to promote quality and efficiency is crucial to achieving desired results.

HHS will be conducting a rigorous evaluation of these demonstrations to see what works and what should be replicated or cast aside. States that are not participating in these demonstrations should track their progress. The demonstrations will provide insight into shared-service arrangements, payment policies, and the integration and coordination of care for dual-eligibles.

In addition to the financial alignment demonstration, many states have begun to move dual-eligibles into risk-based, managed care plans that cover services such as long-term care, dental care, behavioral health, and substance abuse. As of 2010, 24 states and the District of Columbia had enrolled part or all of their dual-eligible population into comprehensive Medicaid managed care plans.[113] A more recent survey in 2012 by the Kaiser Family Foundation found that 34 states were planning new initiatives for their dual-eligible beneficiaries to improve care coordination. As these efforts continue, states can learn from and adopt best practices from the most successful programs.[114]

Action 4–4. Negotiate Contracts to Cover State Employees Through Coordinated, Risk-Based Care

As in the Medicaid program, states should negotiate contracts with health care providers and insurers to provide coordinated, risk-based care to serve state employees. To increase their market influence, states should work with local governments and create common benefit plans for both state and local employees. This would accentuate the purchasing power of both governments.

The availability of coordinated, risk-based plans that meet the state definition will likely be limited in many areas for several years, but to build the capacity needed to transition to higher-value care, states should start by negotiating contracts to provide managed care and risk-based payments. These managed care plans may initially lack some capacity in care coordination, quality monitoring, and use of health IT, but they will be in a position to fill those gaps as the providers gain experience in a managed care environment. Eventually, they should be able to transition into systems that meet the state criteria for coordinated, risk-based care.

To ensure high participation rates, states have several options to encourage employee selection of managed care plans. They can restrict plan availability, offer premium discounts to employees who sign up for such plans, or offer enhanced benefits in those plans.

Action 4–5. Use Health Insurance Exchanges to Encourage the Offering and Selection of Coordinated, Risk-Based Care Plans

Health insurance exchanges, which began enrollment on October 1, 2013, can influence both the type of plans offered in the exchange and the consumer's choice of plans. For the first several years of operation, exchanges should probably encourage all qualified plans to participate. As participation by insurers and consumers grows, exchanges could begin to encourage higher performance in such areas as cost management, quality, and incentives for consumers to purchase value. Exchanges could also consider attracting high-performing plans by promising bonuses if they meet performance targets; the bonuses would be financed using a portion of the user fees charged to plans in the exchange.[115]

Exchanges can help consumers choose plans that deliver high-quality care at affordable costs. They can display each plan's average annual cost of care per person, including premiums and out-of-pocket expenses, along with quality measures to help customers compare plan value. They can use rating systems to point consumers to the highest-value plans. Customer service agents for the exchanges (so-called *navigators*) could be trained to identify the highest-value plans available to those seeking assistance; likewise, the Web site could be designed to list the top-value plans that fit each customer's profile.

Implementing a strategy that brings high-value plans into an exchange will take time. Reorganization of the health care system into coordinated, risk-based care will not happen overnight, and a "shake-down" period will be needed for exchanges to establish themselves as a marketplace. For these reasons, many exchanges will need to encourage all qualified plans to participate during the first years of operation.

Recommendation 5: Encourage Consumer Selection of High-Value Care Based on Cost and Quality Data, and Promote Market Competition

States can help ensure that consumers are given the information they need to consider cost in their health care decisions and that adequate competition exists in the health care marketplace. States can make the cost and quality of health care services more transparent by reporting such information on a statewide basis and requiring plans to publish such information for their members. Antitrust authority can be used proactively and reactively to ensure that consolidation of health care providers achieves greater efficiency and not market leverage over prices.

Action 5–1. Adopt Policies That Require Plans to Provide Consumer-Friendly and Timely Data on Price and Quality

Consumers need accurate, timely, and comparative information on the cost and quality of covered treatment options to make informed choices concerning value. Unfortunately, such information is rarely available or easy to use, and state efforts to provide such information have not been successful in motivating consumers to choose value.

Studies have suggested that only patient-centric and plan-specific information on the cost and quality of medical care can prompt consumers to choose the best value. Only plans can provide this level of detail. Consequently, states should require health plans to report the quality ratings and cost of different procedures, including out-of-pocket expenses, for all hospitals and providers within the plan.

In contrast, state efforts to gather and analyze health care cost and quality data should be used to inform an overall strategy for cost containment and report on the progress and challenges in meeting cost and quality goals.

Action 5–2. Use State Action and Antitrust Powers to Promote Beneficial Consolidation and Limit the Exercise of Market Power

States must remain active in monitoring provider consolidation activities. States should encourage consolidation when it results in more efficient and higher-quality care delivery, but they must discourage consolidation if it leads to market leverage and higher prices.

States can encourage beneficial consolidation by using their "state action doctrine" to allow providers, insurers, and payers to discuss new collaborative models and payment reforms to fulfill a public good—namely, the expansion of risk-based, coordinated care capacity. Such discussions among payers and providers—particularly around payments—would typically be prohibited under antitrust rules, but a state law or regulatory scheme can provide private parties with antitrust immunity if (1) the state has articulated a clear and affirmative policy to allow the anticompetitive conduct and (2) the state actively supervises the anticompetitive conduct.

To provide a "safe harbor" for discussions around delivery system changes and new payment models, several states have passed laws that declare such discussions to be in the best interest of the state and public. Oregon is one such state, having passed legislation in 2011 that stipulates "collaboration among public payers, private health carriers, third party purchasers and providers to identify appropriate service delivery systems and reimbursement methods to align incentives in support of integrated and coordinated health care delivery is in the best interest of the public." (See sidebar, "Oregon Law 646.735: Exemption for Coordinated Care Organizations.") Engaging market participants through a state-sanctioned process not only shields participants from possible legal action but also signals a commitment by the state to support system reforms. However, the state must remain actively engaged in the process to ensure that the "public interest" goals are met. This includes reviewing decisions on provider consolidation to create coordinated care entities

Oregon Law 646.735: Exemption for Coordinated Care Organizations

In 2011, Oregon enacted a law to permit health care payers, providers, and others to work together under state direction to support development of integrated and coordinated care capacity within the state. Below is an excerpt from the law:

(1) "The Legislative Assembly declares that collaboration among public payers, private health carriers, third party purchasers and providers to identify appropriate service delivery systems and reimbursement methods to align incentives in support of integrated and coordinated health care delivery is in the best interest of the public. The Legislative Assembly therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, coordinated care organizations that might otherwise be constrained by such laws. The Legislative Assembly does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state or federal antitrust laws including, but not limited to, agreements among competing health care providers as to the prices of specific health services."

(3) "The Oregon Health Authority may convene groups that include, but are not limited to, health insurance companies, health care centers, hospitals, health service organizations, employers, health care providers, health care facilities, state and local governmental entities and consumers, to facilitate the development and establishment of the Oregon Integrated and Coordinated Health Care Delivery System and health care payment reforms. Any participation by such entities and individuals shall be on a voluntary basis."

and ensuring that payment models promote cost management and quality improvement.

In contrast, states must be prepared to prevent market abuses that may arise from provider consolidation. As Chapter 1 described, hospital and provider consolidation—particularly in smaller market areas—can create dominant health systems that have the ability to set prices based on their market dominance instead of actual costs of services. This phenomenon is often termed *market power* and in the health care industry generally leads to higher prices than observed for similar services in more competitive regions. As pointed out in Chapter 3, antitrust action is a valuable tool for addressing market power, but it is limited and resource intensive.

To stop adverse market impacts before they occur, Massachusetts created the Cost and Market Impact Review (CMIR) process to monitor the effects of proposed mergers and reorganizations.[116] Under the process, providers must notify the state before making material changes to their operations or governance structure. Following a 30-day initial review of that notice, the state can require a full CMIR if the proposed change is likely to result in a significant impact on the state's ability to meet its health care cost growth benchmark or

on the competitive market. By enhancing the transparency of consolidation activities, it is hoped that the need for antitrust action can be avoided.

Recommendation 6: Reform Health Care Regulations to Promote System Efficiency

State health care regulations affecting insurance rules, scope of practice, and medical malpractice can influence health care costs. State should review these policies to determine whether they promote greater effectiveness at lower cost or present obstacles to expanding the availability of risk-based, coordinated care.

Action 6–1. Review and Streamline State Requirements and Mandates

States should review their current list of state benefit mandates, contractual rules between plans and providers, and rules on provider access. These requirements and constraints are typically enforced by state insurance departments and can add to the cost of health services or inhibit the expansion of risk-based, coordinated care.

For example, many states now prohibit insurers from enforcing "most favored nation" (MFN) status in their contracts with providers. MFN clauses require that the insurer—usually the largest one in the state or region—receive the provider's lowest prices for the services specified. If another insurer negotiates a lower rate with the provider for a specific service, the MFN insurer is guaranteed the same rate. Because most providers are reluctant to renegotiate contracts, prices set at the MFN level tend to dictate a floor for all contracts between providers and insurers, thus inhibiting competition.

Likewise, states should consider eliminating "any willing provider" laws. These laws in 22 states require health plans to reimburse equally all providers that comply with preset terms and conditions, even if the provider is not part of the plan's health care delivery network.[117] Such laws can hinder the effectiveness of closed-network managed care plans in which all providers share financial risk in meeting cost and quality targets. Such closed networks often develop a common culture of care delivery that providers outside the network might not share.

Finally, states should establish procedures for reviewing the cost and medical effectiveness of any new state benefit and consider reviewing established mandates in their current list of benefits. As Chapter 3 pointed out, 30 states already have such mandate review laws, and some states review both new and existing mandates. For example, in 2011, Georgia established the Special Advisory Commission on Mandated Health Insurance Benefits, charged with evaluating the social and financial impact of current and proposed mandated benefits. Likewise, Maryland conducts an evaluation of all benefit mandates every 4 years. States should consider conducting comprehensive reviews on all mandated benefits and identify those that may no longer be cost-effective, necessary, or based on current best

practices. An opportunity for states to refine their current mandated benefit lists should occur in 2016, when HHS reviews the EHB rule and considers establishing a national package based on cost and medical effectiveness (see Chapter 3).

Action 6–2. Review State Malpractice Laws

For more than a decade, states have been taking action to reduce the costs of medical malpractice. The goal has been to reduce both direct costs (premium costs and legal expenses) and indirect costs (the expense of unnecessary defensive medicine thought to protect providers from legal action). Chapter 3 described the types of major reforms states have enacted in the past several years. Also discussed were new approaches being considered and tested.

The Commission is not prepared to recommend that states adopt any specific reforms, although some of the newer reforms appear to hold promise, but we do recommend that states conduct a review (if they have not recently done so) of their current malpractice laws in consultation with their provider community. The review should examine recent reforms enacted and considered throughout the states and identify whether any might be useful in lowering malpractice-related costs in the state in question.

Action 6–3. Revise Scope-of-Practice Policies to Allow Providers to Use the Full Range of Their Competencies

The drive toward greater coordination in care delivery and a growing population covered by insurance will strain the supply of skilled providers in many areas, particularly those involved in primary care. To help meet this demand, states should support policies that allow skilled nonphysicians at all levels to practice at the full range of their competencies, including the ability to bill independently.

As described in Chapter 3, the IOM recommended that states make the following changes to scope of practice as it relates to nursing:

- Reform scope-of-practice regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules (Article XVIII, Chapter 18).
- Require third-party payers that participate in fee-for-service payment arrangements to provide direct reimbursement to advanced practice registered nurses who are practicing within their scope of practice under state law.

States that have not already done so should consider adopting similar language (the Commissioners recommend that the reference to "fee-for-service payment" be eliminated to allow reimbursement for all payment models, including bundled and capitated payments). In addition, because medical knowledge and training are continually evolving, states should establish a process to periodically review scope-of-practice rules for all nonphysicians, consider petitions for scope-of-practice amendments, and allow

demonstrations to test the benefits of potential scope-of-practice changes.

Finally, states should consider recognizing the licenses of providers issued by other states. For example, the Nurse Licensure Compact allows nurses to have one multistate license, with the ability to practice in both their home state and other party states. Twenty-four states currently are in the compact.[118]

Recommendation 7: Help Promote Better Population Health and Personal Responsibility in Health Care

States can use public education and the bully pulpit, wellness programs for state employees, and public health initiatives to promote improved population health and healthy behaviors. In addition, states can help individuals to make informed end-of-life treatment choices that reflect their personal wishes.

Action 7–1. Educate Citizens About the Importance of Lifestyle Choices

An important role for states is to educate the public on the value of maintaining a healthy lifestyle. Governors in particular can play a key role in these efforts, and most states today have a gubernatorial initiative designed to promote a "healthier state." Most of these actions require minimal resources and often rely on volunteer efforts.

Governors have several options:

- **Support programs that certify businesses, schools, restaurants, and communities as "healthy sites" if they meet certain criteria.** For example, Oklahoma businesses can be certified as "healthy" by scoring points in one or more of the following areas: (1) screening and evaluation, (2) health education and information, (3) physical activity, (4) tobacco use prevention, (5) nutrition, (6) management support, (7) leadership, (8) behavioral health, and (9) emotional well-being. Based on the total number of points, businesses are awarded a "basic," "merit," or "excellence" certification.[119] In her 2013 state-of-the-state address, Oklahoma Governor Mary Fallin challenged all state businesses and agencies to become a Certified Healthy Business.
- **Sponsor community events such as healthy runs or walks.** For example, Mississippi Governor Phil Bryant—an active runner—recently sponsored the second annual 5K run for health. More than 800 runners joined the race, which also raised money for a local children's hospital.[120]
- **Create councils on physical fitness and nutrition.** Such councils can consist of experts from the community and medical professionals and be used to review and inform public policies that promote healthy behaviors. In Iowa, the Governor's Council on Physical Fitness and Nutrition assists the health department in developing a statewide comprehensive plan for nutrition and physical activity, establishing and promoting a best

practices Web site promoting wellness, and overseeing the Iowa Governor's Challenge for Physical Fitness and Nutrition.[121]

- **Develop wellness initiatives aimed at state employees.** This can improve the health and productivity of the workforce and potentially lower their health care expenses.

Action 7–2. Assist Schools and Community Organizations to Adopt Policies That Promote Healthy Lifestyles

In addition to education, states can support programs that promote healthy lifestyles in schools and communities. These policies often require some state resources and either legislation or executive orders to implement.

Some of the most effective programs occur in schools. These include efforts to improve the nutrition of school meals, remove nonhealthy drinks from vending machines, offer student health assessments and counseling programs, enhance physical education requirements, and provide after-school programs that promote physical activity. Nutrition is particularly important. A 2009 study found that upgraded food nutrition standards in the federal Women, Infants, and Children program had a positive impact on the weight and healthy diets of participating children in New York.[122] The study found a 6 percent decline in obesity among 1-year-old children and a 3 percent decline among 2–4-year-old children 2 years after the new standards were implemented.

Community-based programs to encourage healthy lifestyles also are valuable. States can provide financial resources, including matching funds, to help localities create bike or walking routes to schools, expand community biking and hiking trails, and attract food retail outlets to communities where residents are unable to easily purchase nutritious food because of distance from a market, price, or lack of transportation. Zoning laws can encourage safe pedestrian walking routes in new urban and suburban development areas. A 2012 report by the National Conference of State Legislatures, "State Actions to Promote Healthy Communities and Prevent Childhood Obesity," provides an excellent overview of recent state legislation to promote physical activity, nutrition, and healthy living in schools and communities.[123]

Action 7–3. Work with State Employees to Make Better Lifestyle Decisions

Typically the largest single employer in a state, state governments can use their employee benefit plans to encourage and promote healthier lifestyles among a large portion of the workforce. According to a recent study by the RAND Corporation, approximately half of all U.S. employers offer wellness promotion initiatives, and larger employers are more likely to have more complex wellness programs. Programs often include health assessments to identify risks and interventions to lower risks and promote healthy lifestyles.[124] Many programs also include financial incentives for employees.

States are no exception to this trend, with most sponsoring some type of employee wellness initiative. For example, New Hampshire offers a program called *Healthy Lifestyles*

that includes a health assessment tool and online health coaching programs for exercise and fitness, healthy eating, stress or weight management, quitting tobacco, medication or appointment management, depression prevention, and self-care. Employees who take the assessment can receive $200 toward the cost of medical and pharmacy co-payments.[125]

Arkansas has several initiatives, including a program that allows state employees to earn up to 3 days of extra leave per year for increasing physical activity, increasing consumption of fruits and vegetables, and decreasing or eliminating the use of tobacco products.[126] Alabama uses employee discounts on premiums to encourage healthy behaviors, including weight loss. The 2013 active base employee contribution (or premium) is $85 per month, but employees can reduce this amount by participating in the wellness program ($25 discount per month) and refraining from using tobacco products ($45 discount per month).[127] Employees who do not test in the healthy range for blood pressure, cholesterol, glucose, and BMI must remain in the wellness program to obtain the discount.

Getting employees to actively participate in a wellness program can yield positive results. In the RAND study mentioned above, researchers found " . . . statistically significant and clinically meaningful improvements in exercise frequency, smoking behavior, and weight control, but not cholesterol control." They also found positive cumulative effects with ongoing program participation.[128]

Action 7–4. Educate Citizens on the Value of Creating Instructions for End-of-Life Care

As described in the introduction, a large portion of health care costs occurs in the final years of a person's life. In many instances, treatment often involves unnecessary and unwanted interventions that do not significantly prolong life or improve a patient's quality of life. In fact, aggressive care often diminishes quality of life and strains family budgets through out-of-pocket costs.

Many patients do not want this unnecessary and costly care but fail to make their choices clear before becoming incapable of managing their own medical decisions. As a result, 70 percent of Americans die in institutional settings, even though the same percentage actually wants to die at home.[129] To counter this phenomenon, states can assist in ensuring that patients are given the opportunity to make informed end-of-life decisions, including the option of access to palliative and hospice care (see sidebar, "The Benefits of Hospice Care").[130]

Two types of documents are particularly important: advanced directives (AD) and physician orders for life-sustaining treatment (POLST). Both establish patient guidelines for care and complement each other. ADs, which cover anyone 18 years of age and older, require that the patient appoint a health care representative and set guidelines for inpatient treatment, but they do not guide emergency medical personnel. ADs are intended to be completed by patients when they are healthy.

In contrast, POLST forms are chiefly designed for patients with advanced illnesses.

The POLST form guides current treatment (as distinct from future treatment covered by an AD) and guides actions by emergency personnel. It does not establish a health care representative.

The federal Patient Self-Determination Act of 1990 requires providers to inform all adult patients about their rights to accept or refuse medical or surgical treatment and the right to execute an AD, but the responsibility for completing an AD remains with the patient, and most providers and insurance plans do not actively encourage the creation of an AD. Although ADs have become more important over time, two-thirds of Americans still do not have either an AD or living will.[131] Some have suggested that states establish more aggressive strategies, such as requiring an AD as part of the hospital admission process or providing information on ADs when renewing driver licenses or voting registration.

Programs implementing POLST are newer. About a quarter of states have created POLST programs, and most others are developing them. However, a 2011 study found that only two states require that health care facilities offer POLST to certain patients, and no state requires a POLST form for people suffering advanced progressive illness or extreme frailty.[132] States that have not done so should consider establishing POLST laws and require providers to ask patients to complete a POLST form when treated for advanced illnesses.

Ensuring Long-Run Progress

The proceeding recommendations rely largely on the use of transparency, purchasing power, payer and provider cooperation, persuasion, and "soft" regulatory pressure to spur the growth of coordinated care organizations using risk-based payments. The transition will take years and require active participation by all payers and stakeholders to insure that negotiated payments are affordable and encourage efficiency improvements. Using information gleaned by data-transparency efforts, the state and other payers must maintain pressure on provider costs, particularly those that exceed growth rates and state averages.

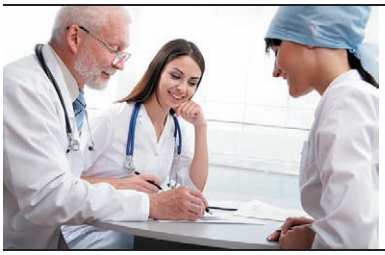
The first 3–5 years of a cost-management strategy should emphasize reporting and disclosure, but over time, health care systems that consistently exceed cost growth targets and show little sign of improvement may need firmer signals from the state and other health care payers. As described in Chapter 3, states have several powers at their disposal to spur greater compliance.

The Benefits of Hospice Care

Hospice care can dramatically increase quality of life for both patients and families who wish to forego costly and aggressive treatment. More than 90 percent of hospices in the United States are certified by Medicare, and their certification requires them to provide physician services; nursing care; physical and occupational therapy; speech therapy; medical appliances and supplies; pharmaceuticals for symptom management and relief; short-term inpatient and respite care; home health aide services; and counseling and spiritual care, including bereavement services for the patient's family members. A recent study found that Medicare saves $6.4 million for every 1,000 patients who are in hospice for 15–30 days relative to traditional Medicare.

Although hospice use has grown, it remains underutilized. In 2011, approximately 45 percent of all deaths occurred in hospice, but the median stay was only 19 days. This underutilization depends at least partially on difficulty in discussing or accepting hospice as a treatment option; demographic factors, including race or ethnicity; and misconceptions of financial and eligibility requirements.

Hospice can be used to provide palliative care to patients who suffer from chronic ailments but do not have a terminal illness or face imminent death. States can make it easier for licensed hospice facilities to deliver palliative care to patients being served by health plans, HMOs, or nursing homes. For example, New York addressed the issue by passing Public Health Law §4012-b in 2010. The law permits a hospice acting alone or under contract with a certified home health agency, a long-term home health care program (New York's version of the Program for All-Inclusive Care of the Elderly), a licensed home care services agency, or an AIDS home care program to provide palliative care to patients "with advanced and progressive disease" and their families. A hospice palliative care program in New York can bill third-party payers but not Medicare, Medicaid, or other government-funded health plans for these palliative care services. However, the third-party payer can bill Medicare or Medicaid as appropriate under their service contract to offer palliative care. The rationale for this rule is that the definition of Medicare hospice services requires that a hospice program be "primarily engaged"—but not "exclusively engaged"—in providing hospice care and services to terminally ill patients.



5. Recommended Changes to Federal Policy

The federal government can complement and assist state efforts to transform U.S. health care from a traditional fee-for-service model to one that is coordinated, using risk-based payments to deliver higher-quality care at reduced costs. To achieve this, the Commission recommends the following federal actions:

- Provide Medicaid, Medicare, and other federal health claims data to states.
- Accelerate, expand, and replicate demonstration programs for the dual-eligible population.
- Work toward common criteria and guidelines for ACOs.
- Increase research to determine effective programs that affect population health.
- Develop national guidelines on scope-of-practice models for all major categories of non-physician providers.
- Assist states in using Medicaid to accelerate the transformation to patient-centered, high-performing health care.
- Provide incentives to states to adopt policies that contain costs and improve care quality across the entire health system.

Many of these recommendations can be accomplished through regulatory and executive action, although some may require new legislation. In combination, they can strengthen the effectiveness of states in their quest to develop appropriate strategies to enhance quality and reduce the rate of increase in health care spending over time.

Provide Medicaid, Medicare, and Other Federal Health Claims Data to States

HHS should provide Medicaid and Medicare claims data to all states in a timely manner so they can use it in their analysis of state health care costs and spending trends. The federal government should also make claims data from TRICARE and the Federal Employee Health Program available, particularly for states that have a large presence of military personnel (or their retirees) or federal workers.

Existing statutes and regulations related to individual privacy should be reviewed to

ensure that privacy is protected. HHS should work with states and the private sector to set standards so that accurate comparisons across federal and private-sector claims are possible. Claims data should be made available to researchers who agree to comply with privacy protections.

Implement, Evaluate, and Replicate Demonstration Programs for the Dual-Eligible Population

The dual-eligible population is challenging to manage, and the current approach for delivering care costs state and federal governments a total of $315 billion—one-third of the total costs of government health programs. Dual-eligible individuals are generally poor, frail, and elderly, and they total approximately 9.1 million throughout the states. Medicare pays 55 percent of the total, while Medicaid pays the rest, primarily for long-term care and the gaps that Medicare does not cover. Not only is this population expensive, but it generally receives poor-quality care because services are uncoordinated.

The Centers for Medicare and Medicaid Services (CMS) has finalized memoranda of understanding with eight states to implement demonstrations to integrate care and align financing and administration for people who are dually eligible for Medicare and Medicaid.[133] Six of the demonstrations will test a capitated financial alignment model. Proposals from 14 other states are pending. These demonstrations should provide the best information on effective practices and new system design to improve the cost management and quality of dual-eligible care. As preliminary results begin to emerge, they should be evaluated, made available to all states, and be used to inform the overall scope and direction of the demonstration program.

Currently, the necessity of generating savings quickly and the need for start-up capital and reserves have limited the approaches that can be tested. CMS should work with states, providers, consumers, and other stakeholders to address ways to overcome these obstacles and allow a broader array of models to be examined.

Work Toward Common Nationally Accepted Criteria and Guidelines for ACOs

The definition, design, and operation of ACOs at both the state and federal level are in their infancies and likely will change over time based on experience. In the near term, the federal government and states should share information that is helpful in creating a set of common criteria and guidelines for ACOs that should address each element of the definition. The 33 quality measures currently adopted for Medicare ACOs also should continue to be revised and include more outcomes-based measures, including some for patient engagement.

Given that many of the current ACO measures apply to an elderly population, states will need to continue to develop other criteria and guidelines for ACOs that serve nonelderly populations. HHS should consider creating supplemental criteria and guidelines for ACOs that serve special-needs populations, such as individuals who need long-term care services.

Increase Research to Determine Effective Programs that Affect Population Health

Nutrition, sedentary lifestyles, obesity, smoking, drug use, crime, and lack of education all have major negative impacts on health outcomes, but much less is known about which public health interventions are most effective in changing unhealthy behavior. Most states currently have numerous programs in communities, schools, and workplaces focused on obesity and other lifestyle changes, but not enough adequate research is being conducted to determine which programs are working and what type of new approaches or innovations hold promise. HHS should sponsor additional studies that provide information on current best practices and their effectiveness as well as promising new strategies.

Develop National Guidelines on Scope-of-Practice Models for All Major Categories of Nonphysician Providers

The IOM has already made recommendations to states concerning scope-of-practice policies for nurses. HHS should contract with IOM to conduct additional studies and recommend scope-of-practice policies for states in other categories of nonphysician providers, such as PAs, physical and occupational therapists, mental health providers, and even dental assistants. Furthermore, the federal government may want to assist states in developing additional compacts for reciprocity on licenses between states to reduce the barriers to mobility and thus create more effective utilization of the health care workforce.

Assist States in Using Medicaid to Accelerate the Transformation to Patient-Centered, High-Performing Care

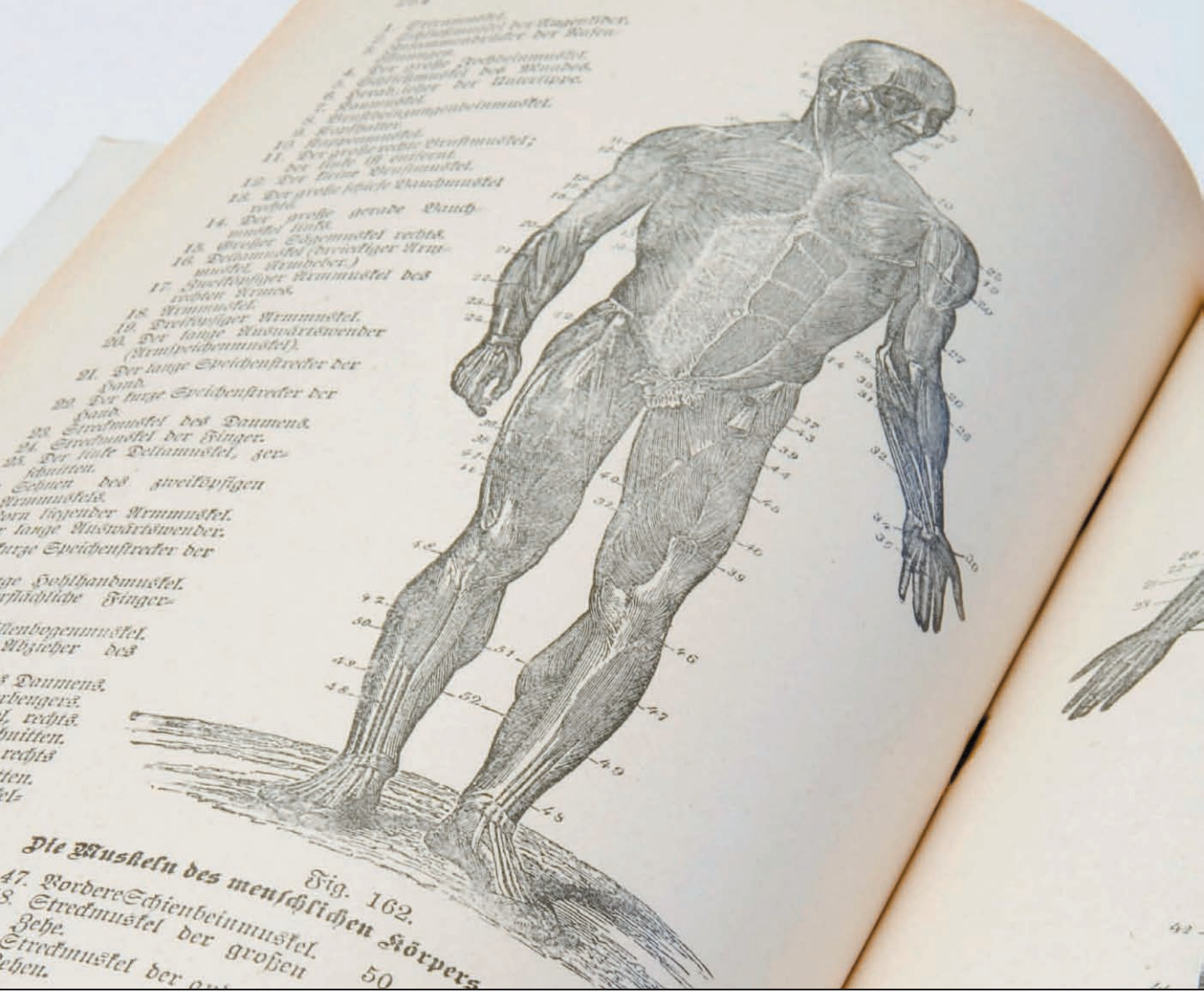
Lack of administrative capacity frequently inhibits states from developing and implementing innovative approaches to organizing and paying for care that could improve quality and reduce costs. The federal government should enhance the Federal Medical Assistance Percentage (FMAP) available to states to implement innovations in payment and delivery in a manner similar to the enhanced FMAP that was made available to develop IT systems. In addition, building on provisions in the ACA, the federal government should work with

states to develop an expanded list of payment and delivery reform initiatives that would be eligible for enhanced matching funds. Both types of initiatives could be designed in a way that is budget neutral for the federal government. Finally, the federal government should work with the states and other stakeholders to identify a process (such as the use of common templates) for expediting approval of certain waivers that have been evaluated and shown to provide high-quality care in a cost-effective manner.

Provide Incentives to States to Adopt Policies That Contain Costs and Improve Care Quality Across the Entire Health System

A bold approach to incentivizing state action is to reward states for holding the growth in total per-capita health care costs—including Medicaid and Medicare—to a level at or below an agreed-upon target rate. Under such an approach, HHS would negotiate a growth rate with the state for per-capita health care spending based on historical experience. States would then receive a small bonus, such as an increase in their FMAP, if they manage to slow the actual rate of increase in total health care spending relative to the negotiated rate. The bonuses could be tiered so that the state payment grows as the gap between the actual growth and the negotiated rate widens. Quality standards would be part of the negotiation so that states could not sacrifice quality to attain spending reductions.

The bonuses should be set so that the added federal payment to states is more than offset by the federal government's own savings in Medicare and Medicaid. In addition, the state bonus need not be too high, because states have their own incentive in Medicaid savings. This approach should benefit state and federal governments, citizens, and businesses and encourage states to address total health care spending instead of just Medicaid.



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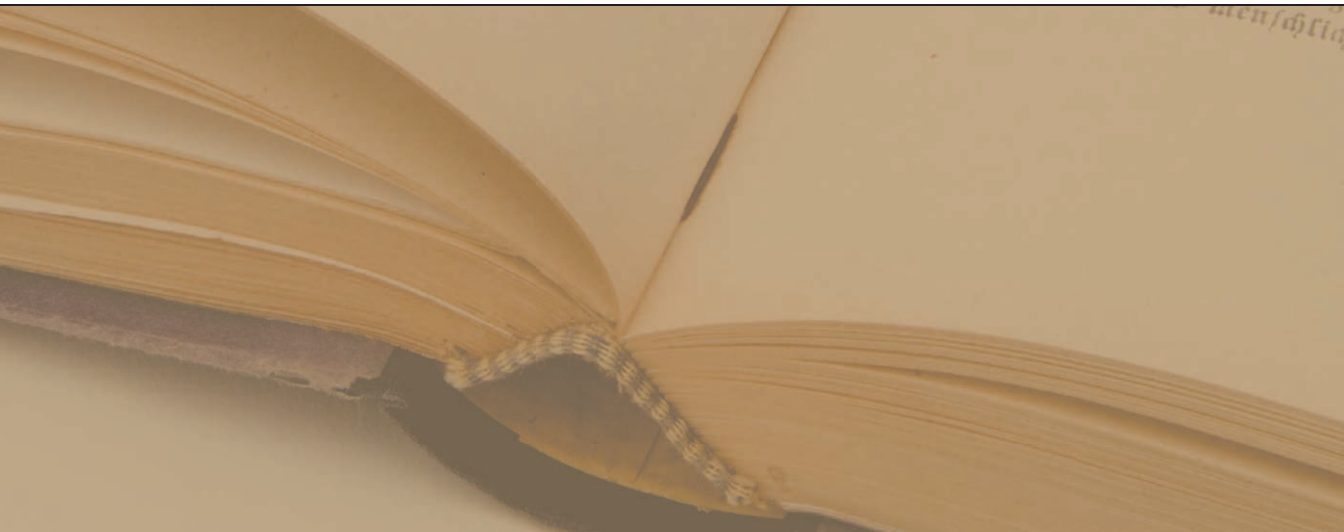


THE HONORABLE MICHAEL O. LEAVITT

Founder and Chairman
Leavitt Partners

Michael O. Leavitt is the founder and chairman of Leavitt Partners, where he advises clients in the health care and food safety sectors. In 1993, Leavitt was elected governor of Utah, where he served three terms (1993–2003). In 2003, he joined the Cabinet of President George W. Bush, serving in two positions—first as leader of the Environmental Protection Agency (2003–2005), and then as Secretary of Health and Human Services (2005–2009).

Leavitt grew up in Cedar City, Utah, where his upbringing was rooted in the values of the American West, with its emphasis on hard work and common sense. He earned a bachelor's degree in business while working in the insurance industry. In 1984, he became chief executive of The Leavitt Group, a family business that is now the nation's second-largest privately held insurance brokerage.

Leavitt's strategic ability can be seen in his redesign of the nation's system of quality and safety standards for imported goods. In the spring 2006, President Bush assigned him to lead a governmentwide response. Within months, Leavitt recommended a major strategic shift in U.S. policy on import regulation and trade.

Collaborator is a word that comes up repeatedly when one examines Leavitt's background. His skill led his governor colleagues to elect him chairman of the National Governors Association, the Republican Governors Association, and the Western Governors' Association.

Leavitt is a seasoned diplomat, having led U.S. delegations to more than 50 countries. He has conducted negotiations on matters related to health, the environment, and trade. At the conclusion of his service, the Chinese government awarded him the China Public Health Award—the first time this award has ever been given to a government official.

He and his wife Jackie have been married nearly 37 years. They have five children and eight grandchildren. The Leavitts live in Salt Lake City, Utah.

THE HONORABLE BILL RITTER JR.

Director, Center for the New Energy Economy
Colorado State University

Bill Ritter Jr. is currently the director of the Center for the New Energy Economy at Colorado State University. The Center started February 1, 2011, with Ritter as the founding director. In addition to the director, the Center employs an assistant director, three senior

policy advisors, and an executive assistant.

Ritter was elected Colorado's 41st governor in 2006 and served as Denver's district attorney from 1993 to 2005. Ritter led Colorado forward by bringing people together to tackle some of our state's biggest challenges. During his four-year term, Ritter established Colorado as a national and international leader in clean energy by building a New Energy Economy. As a result of that work, Colorado created thousands of new jobs and established hundreds of new companies. Ritter also enacted an aggressive business-development and job-creation agenda that focused on knowledge-based industries of the future, such as energy, aerospace, biosciences, information technology, and tourism.

He earned his bachelor's degree in Political Science from Colorado State University (1978) and his law degree from the University of Colorado (1981).

ANDREW DREYFUS

President and Chief Executive Officer
Blue Cross Blue Shield of Massachusetts

Andrew Dreyfus is president and chief executive officer (CEO) of Blue Cross Blue Shield of Massachusetts (BCBSMA). Serving nearly 3 million members, BCBSMA is one of the largest independent, non-profit Blue Cross Blue Shield plans in the country. As CEO, Dreyfus leads the company's effort to make quality health care affordable.

Prior to being named CEO in September 2010, Dreyfus served as BCBSMA's executive vice president of Health Care Services. In that position, he led the company's collaborative efforts to improve the quality and safety of health care in Massachusetts, including the development of BCBSMA's Alternative Quality Contract, an innovative model that is currently one of the largest commercial payment reform initiatives in the nation.

Dreyfus previously served as the first president of BCBSMA Foundation, which works to expand access to health care for Massachusetts' residents. During his tenure, the Foundation launched a series of policy initiatives, including the "Roadmap to Coverage," which contributed to the successful passage of the state's landmark 2006 Health Reform Law.

Dreyfus is chairman of the board of the United Way of Massachusetts Bay and Merrimack Valley and also serves on the board of the Schwartz Center for Compassionate Healthcare, the National Institute for Health Care Management, Jobs for Massachusetts, and the Boston University School of Public Health Dean's Advisory Board and the Ariadne Labs Advisory Board.

Dreyfus previously served as executive vice president of the Massachusetts Hospital Association and held a number of positions in Massachusetts state government, including Undersecretary of Consumer Affairs and Business Regulation.

SIMON STEVENS

Executive Vice President
UnitedHealth Group
President, Global Health

Simon Stevens is president, Global Health, at UnitedHealth Group, providing health and well-being services for 89 million people in more than 120 countries. As executive vice president of UnitedHealth Group, Stevens leads UnitedHealth's work on U.S. health reform and innovation. He was previously chief executive officer of UnitedHealth's $30 billion Medicare company and before that was British Prime Minister Tony Blair's Health Adviser at 10 Downing Street. He has run hospitals, primary care, and payer/health commissioning organizations on both sides of the Atlantic and has worked in Africa and South America. He is a nonexecutive director of several international health organizations, including the Commonwealth Fund and the Nuffield Trust; has been visiting professor at the London School of Economics; and was educated at Oxford University, Strathclyde University, and Columbia University.

GLENN D. STEELE JR., M.D.

President and Chief Executive Officer
Geisinger Health System

Glenn D. Steele Jr., M.D., Ph.D., is president and chief executive officer (CEO) of Geisinger Health System, an integrated health services organization in central and northeastern Pennsylvania nationally recognized for its innovative use of the electronic health record and the development and implementation of innovative care models. Steele previously served as the dean of the Biological Sciences Division and the Pritzker School of Medicine, vice president for Medical Affairs at the University of Chicago, and the Richard T. Crane Professor in the Department of Surgery. Prior to that, he was the William V. McDermott Professor of Surgery at Harvard Medical School, president and CEO of Deaconess Professional Practice Group (Boston, Massachusetts), and chairman of the Department of Surgery at New England Deaconess Hospital (Boston, Massachusetts). Steele is past chairman of the American Board of Surgery. His investigations have focused on the cell biology of gastrointestinal cancer and precancer and most recently on innovations in health care delivery and financing. A prolific writer, he is the author or co-author of more than 481 scientific and professional articles.

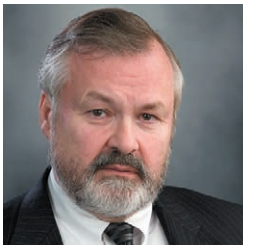
Steele received his bachelor's degree in History and Literature from Harvard University and his medical degree from New York University School of Medicine. He completed his internship and residency in surgery at the University of Colorado, where he was also a

fellow of the American Cancer Society. He earned his Ph.D. in microbiology at Lund University in Sweden.

A member of the Institute of Medicine of the National Academy of Sciences, Steele serves as a member on the Roundtable on Value and Science-Driven Healthcare, was recently appointed to the Committee on the Governance and Financing of Graduate Medical Education, and served on the Committee on Reviewing Evidence to Identify Highly Effective Clinical Services. A fellow of the American College of Surgeons, Steele is a member of the American Surgical Association and the American Society of Clinical Oncology and is past president of the Society of Surgical Oncology.

GEORGE C. HALVORSON

Former Chairman and Chief Executive Officer
Kaiser Permanente



George C. Halvorson served as chairman and chief executive officer (CEO) of Kaiser Permanente from 2002 to 2013. Headquartered in Oakland, California, Kaiser Permanente is the nation's largest nonprofit health plan and hospital system, serving more than 9 million members and generating about $50 billion in annual revenue.

Halvorson is now chairman and CEO of the Institute for Intergroup Understanding and also chairs the First 5 California Children and Families Commission. The Institute works on issues of ethnic and racial conflict. The Commission works on creating optimal health and learning opportunities for the children of California under 5 years of age.

Kaiser Permanente has been investing heavily in electronic medical records and physician support systems over the past 5 years. More than 9 million patients now have their records in Kaiser Permanente's computers. The medical records are designed to provide real-time information to patients and physicians and to provide the tools to coordinate their care among physicians, nurses, and other caregivers.

Kaiser Permanente is a leader in electronic connectivity between physicians and patients, with more than 12 million yearly "e-visits" chosen by patients instead of face-to-face clinical visits and more than 100 million lab reports, test results, and care updates sent to patients by their Kaiser Permanente care team.

Care improvement programs that Kaiser Permanente computer systems support have dramatically diminished rates of sepsis and pressure ulcers, cut human immunodeficiency virus death rates to half the national average, improved heart disease survival, and significantly reduced the number of broken bones for Kaiser Permanente members.

Medical research that the Kaiser Permanente database supports has affected the use of Vioxx, heart stents, various joint implants, and medical treatments for expectant mothers.

Kaiser Permanente is building one of the world's largest DNA data sets for health care

research, with nearly 200,000 patient DNA samples having been collected and added so far.

Halvorson was recently honored with the 2013 HISTalk Health Care IT Lifetime Achievement Award as well as America's Health Insurance Plans (AHIP) Inaugural Lifetime Achievement Award. He has received the *Modern Healthcare*/Health Information and Management Systems Society CEO IT Achievement Award, and the Workgroup for Electronic Data Interchange awarded him the 2009 Louis Sullivan Award for leadership and achievements in advancing health care quality.

In 2012, Halvorson was the social media chair for the Global Health Policy Forum and was named No. 6 on *Modern Healthcare*'s annual 100 Most Influential People in Healthcare list. Halvorson has served on the Institute of Medicine (IOM) Roundtable on Value and Science-Driven Health Care, the IOM Task Force on Making America a Learning Health Care Organization, the American Hospital Association's Advisory Committee on Health Reform, The Commonwealth Fund Commission on a High Performance Health System, and the New America Foundation Leadership Council. He has served on the boards of the National Committee for Quality Assurance, AHIP, and the Alliance of Community Health Plans.

Halvorson chaired the International Federation of Health Plans and co-chaired the Institute for Healthcare Improvement Annual National Forum on Quality Improvement in Health Care for 2010. In 2009, he chaired the World Economic Forum's Health Governors meetings in Davos.

Halvorson has written six health care reform guidebooks, including *Ending Racial, Ethnic and Cultural Disparities in American Health Care*, *Health Care Will Not Reform Itself: A User's Guide to Refocusing and Reforming American Health Care*, *Health Care Reform Now!*, *Health Care Co-ops in Uganda*, *Strong Medicine*, and *Epidemic of Care*. In 2012, he published *KP Inside: 101 Letters to Us at Kaiser Permanente*, which is a compilation of letters he has written to Kaiser Permanente employees each week since September 27, 2007.

Halvorson served as an advisor to the governments of Uganda, the United Kingdom, Jamaica, and Russia on issues of health policy and financing. His strong commitment to diversity and interethnic healing has led him to his current writing project, a new book about racial and ethnic prejudice and intergroup conflict around the world.

Prior to joining Kaiser Permanente, Halvorson was president and CEO of HealthPartners, headquartered in Minneapolis, Minnesota, for nearly 18 years. With more than 30 years of health care management experience, he has also held several senior management positions with Blue Cross and Blue Shield of Minnesota and Health Accord International.

JAY J. COHEN, M.D., MBA

Senior Vice President, External Affairs
Optum

Since November 2012, Jay Cohen has served as senior vice president of External Affairs for Optum Collaborative Care. He is also executive chairman of Monarch HealthCare, A Medical Group, Inc. (Monarch), an independent practice association headquartered in Irvine, California. Monarch serves more than 2,300 physicians who care for approximately 200,000 health maintenance organization and preferred provider organization members throughout Orange County and Long Beach, California, and is proud to have been designated a 2012 Pioneer Accountable Care Organization (ACO) by the Center for Medicare and Medicaid Services. Monarch HealthCare was acquired as an affiliate of Optum in November 2011.

Prior to co-founding Monarch, Cohen served as vice president and medical director for Pacific Physician Services, Inc. Concurrent with his executive responsibilities, Cohen served as a clinician for 18 years, initially as an emergency physician and most recently as a primary care physician in Mission Viejo, California.

Cohen has served on numerous governing boards, including the California Association of Physician Groups (CAPG), Mission Hospital Regional Medical Center, the National Association of ACOs, and Age Well Senior Services. He is past chairman of the Physician Groups for Coordinated Care and past chairman of the CAPG board of directors. He is also a member of the University of California, Irvine (UCI) Health Care Management and Policy Board of Advisors at The Paul Merage School of Business and assistant clinical professor at the UCI School of Medicine, where he helps teach residents and medical students about the health care industry.

Cohen received his bachelor's degree and medical degree from Indiana University and his MBA from the University of Phoenix. His family practice residency was at St. Francis Hospital Medical Center in Indianapolis, Indiana. He is board certified in emergency medicine and as a physician executive.

JOAN HENNEBERRY

Principal
Health Management Associates

Joan Henneberry joined Health Management Associates in January 2012 after serving as the planning director for the health insurance exchange in Colorado, where she developed the strategic plan for the establishment of an exchange, staffed the first board of directors, monitored and responded

to proposed rules and regulations, and developed four working groups of stakeholders and experts to advise the planning process. From 2007 to 2011, Henneberry served on the cabinet of Governor Bill Ritter Jr. as the executive director of the Department of Health Care Policy and Financing, the state agency responsible for public health insurance programs, including Medicaid and Child Health Plan Plus. She was the senior health policy advisor to the governor, developing and implementing policies and programs that expanded the availability of public health insurance programs for the State of Colorado. Between 1997 and 2004, Henneberry held several positions at the National Governors Association in Washington, DC, including director of Health Policy.

Henneberry serves on several state and national boards and advisory committees and sits on the board of Senior Support Services in Denver, Colorado. She has a master's degree in Management from Regis University and completed the Senior Executives in State and Local Government program at the Harvard University Kennedy School of Government in 2008. Henneberry was the 2011 recipient of the John Iglehart Award for Leadership in Health Policy from The Colorado Health Foundation.

ROBERT D. REISCHAUER

Medicare Trustee

Robert Reischauer is an economist and one of the two public trustees of the Social Security and Medicare trust fund. He is a nationally known expert on the federal budget, health reform, Medicare, and Social Security. Most recently (2000–2012), he served as president of the Urban Institute, a nonpartisan social and economic policy research institute in Washington, DC. He is the son of renown Japan scholar Edwin O. Reischauer.

Reischauer was director of the Congressional Budget Office (CBO) from 1989 to 1995. Prior to that, he helped Alice Rivlin set up the CBO in 1975 and served as the assistant director for Human Resources and its deputy director between 1977 and 1981.

Reischauer served as senior vice president of the Urban Institute from 1981 to 1986. He was a senior fellow of Economic Studies at the Brookings Institution from 1986 to 1989 and from 1995 until 2000. He began his tenure as the second president of the Urban Institute in February 2000 and left that role in 2012.

Reischauer serves on the boards of several educational and nonprofit organizations. He was a member of the Medicare Payment Advisory Commission from 2000 to 2009 and was its vice chair from 2001 to 2008. He frequently contributes to the opinion pages of the nation's major newspapers, comments on public policy developments on radio and television, and testifies before congressional committees.

Reischauer is also senior fellow (i.e., chairman) of the Harvard Corporation. He has a bachelor's degree from Harvard University and a Ph.D. in economics from Columbia University.

LLOYD H. DEAN

President/Chief Executive Officer
Dignity Health

Lloyd H. Dean is a nationally recognized leader within and beyond the field of health care. He is president and chief executive officer of Dignity Health (formerly Catholic Healthcare West), an integrated nonprofit health care system, consisting of 40 hospitals and many ambulatory care centers in three western states.

Dean is responsible for the organization's $13 billion in assets as well as overall management, governance, strategy, and direction. He has led Dignity Health through significant strategic, operational, and financial transformations and has brought the organization to its current status as a leading health care organization recognized for high-quality, compassionate care; operational excellence; and successful financial results.

Prior to joining Dignity Health in 2000, Dean was executive vice president and chief operating officer of Advocate Health Care, a faith-based integrated health care delivery system in Oak Brook, Illinois. Prior to Advocate Health Care, Dean was with the Upjohn Company, where he held key executive and operational management positions for the company's Health Care Services Division, including national vice president of sales and executive vice president of marketing. He received the prestigious W.E. Upjohn Award for his management and operational excellence.

A strong advocate for health care reform, Dean has been actively engaged with the White House Cabinet on health care issues. He directly participated in health care reform discussions with President Barack Obama and his staff at the White House in support of Dignity Health's commitment to the disenfranchised and underserved.

Dean holds a degree in sociology and education from Western Michigan University and received an honorary doctorate of humane letters from the University of San Francisco. In 2011, he was ranked number 19 in *Modern Healthcare*'s 100 Most Influential People in Healthcare and is consistently named one of the Top 25 Minority Leaders in Healthcare.

ROBERT RESTUCCIA

Executive Director
Community Catalyst

Robert Restuccia is the executive director of Community Catalyst, a national advocacy organization that is building consumer and community participation in the shaping of our health system. Through Restuccia's leadership, Community Catalyst has become a national voice for consumers on health issues and is working with advocates in more than 40 states

to provide the knowledge, resources, and strategic advice they need to effectively bring the consumer perspective to health care policy. Community Catalyst played an important role in the passage of the Patient Protection and Affordable Care Act (ACA) and now administers the ACA Fund, a collaboration of seven national foundations that support the work of state-level consumer organizations in implementing the law. Community Catalyst is currently the national program for Consumer National Program for Consumer Voices for Coverage and Roadmaps to Health and leads numerous other national projects related to health access, cost, and quality.

Prior to joining Community Catalyst, Restuccia was a co-founder and executive director of Health Care For All in Massachusetts. He is a founder and was the first president of the Commonwealth Care Alliance, a nonprofit health care delivery system that is a pioneer in providing integrated care for seniors and others who have chronic disease and complex needs, and currently serves on its board of directors. He also serves on the board of directors of the Herndon Alliance, Health Care For All, and the Blue Cross Blue Shield Foundation of Massachusetts.

Restuccia has a bachelor's degree from Harvard University and master's degree from Harvard's Kennedy School of Government. Restuccia is an adjunct professor at the Boston University School of Public Health.

MIKE DAVIS

Senior Vice President, Global Human Resources
General Mills

Mike Davis is senior vice president, Global Human Resources, with responsibility for all human resource functions at General Mills. Previously, he was vice president, Human Resources, U.S. Retail and Corporate, for 3 years; prior to that, he served for 9 years as vice president, Compensation & Benefits.

Before joining General Mills, Davis worked for 15 years as a compensation consultant with Towers Perrin. When he left Towers Perrin in 1996, Davis was the firm's worldwide practice leader for executive compensation.

Davis has also been an adjunct professor for 6 years in the graduate human resources program at the Carlson School of Management at the University of Minnesota.

Davis is on the board and is the board chairman of the Employee Benefits Research Institute. He serves on the boards of the Human Resource Policy Association, National Committee for Quality Assurance (in health care), and WorldatWork, as well. He was previously the board chair and a board member of the National Business Group on Health. In Minneapolis, he serves on the board of The Minneapolis Club and is on the Compensation Committee of Allina Health System.

Davis has two undergraduate degrees from Purdue University in Industrial Management and Computer Science, respectively, and an MBA from the University of Chicago. He is also a certified public accountant.

Endnotes

1 U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, "National Health Expenditure Data," 2012, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (accessed March 11, 2013).

2 National Research Council, "U.S. Health in International Perspective: Shorter Lives, Poorer Health," January 2013, http://sites.nationalacademies.org/xpedio/groups/dbassesite/documents/webpage/dbasse_080620.pdf (accessed January 2013).

3 Ibid.

4 Ellen Nolte and C. Martin McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," *Health Affairs* 27, no. 1 (2008): 58–71.

5 Elizabeth Docteur and Robert Berenson, "How Does the Quality of U.S. Health Care Compare Internationally?" The Urban Institute, August 2009, http://www.urban.org/uploadedpdf/411947_ushealthcare_quality.pdf (accessed March 27, 2013).

6 The Commonwealth Fund Commission on a High Performance Health System, "Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System," The Commonwealth Fund, January 2013, http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Jan/1653_Commission_confronting_costs_web_FINAL.pdf (accessed March 12, 2013).

7 Centers for Medicare & Medicaid Services, 2012.

8 David I. Auerbach and Arthur L. Kellermann, "A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average U.S. Family," *Health Affairs* 30, no. 9 (2011): 1630–6.

9 The Henry J. Kaiser Family Foundation, "Health Security Watch," June 2012. http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8322_hsw-may2012-update.pdf. (Accessed November 28, 2013).

10 Anna Sommers and Peter J. Cunningham, "Medical Bill Problems Steady for U.S. Families, 2007–2010," The Center for Studying Health System Change, Tracking Report No. 28, http://www.hschange.com/CONTENT/1268/1268.pdf (accessed March 13, 2013).

11 U.S. Congress, Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2013 to 2023," February 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf (accessed March 18, 2013).

12 Kathleen Sebelius, "2012 Actuarial Report on the Financial Outlook for Medicaid," Report to U.S. Congress, U.S. Department of Health and Human Services, 2012, http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf (accessed March 18, 2013).

13 National Association of State Budget Officers, "State Expenditure Report," 2012, http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report_1.pdf (accessed September 9, 2013).

14 Gretchen Jacobson, Tricia Neuman, and Anthony Damico, "Medicare's Role for Dual Eligible Beneficiaries," Kaiser Family Foundation Issue Brief, April 2012, http://www.kff.org/medicare/upload/8138-02.pdf (accessed March 19, 2013).

15 U.S. Department of Labor, Bureau of Labor Statistics, "Employee Benefits in the United States," News Release, USDL–12–1380, July 11, 2012, http://www.bls.gov/news.release/pdf/ebs2.pdf (accessed March 18, 2013).

16 Centers for Medicare & Medicaid Services, 2012.

17 Elise Gould, "Employer-Sponsored Health Insurance Coverage Continues to Decline in a New Decade," Economic Policy Institute, December 5, 2012, http://www.epi.org/publication/bp353-employer-sponsored-health-insurance-coverage (accessed March 18, 2013).

18 The Henry J. Kaiser Family Foundation, "Health Care Costs: A Primer," May 2012, http://www.kff.org/health-costs/report/health-care-costs-a-primer. (accessed October 26, 2013).

19 Len M. Nichols and Sarah Axeen, "Employer Health Costs in a Global Economy: A Competitive Disadvantage for U.S. Firms," New America Foundation, May 2008, http://www.newamerica.net/files/nafmigration/EMPLOYER_HEALTH_COSTS_IN_A_GLOBAL_ECONOMY.pdf (accessed March 18, 2013).

20 International Federation of Health Plans, "2011 Comparative Price Report Medical and Hospital Fees by Country," 2011, http://www.indiana.edu/~uhrs/UFCBC/pubs/2011iFHPPriceReportGraphs_version3.pdf (accessed March 20, 2013).

21 Miriam Laugesen and Sherry Glied, "Higher Fees Paid to U.S. Physicians Drive Higher Spending for Physician Services Compared to Other Countries," *Health Affairs* 30, no.9 (2011): 1647–56.

22 David Squires, "Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality," The Commonwealth Fund, May 2012, http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/May/1595_Squires_explaining_high_hlt_care_spending_intl_brief.pdf (accessed March 20, 2013).

23 Organisation for Economic Co-operation and Development, "OECD Health Date 2012," OECD Health Statistics. http://www.oecd-ilibrary.org/social-issues-migration-health/data/oecd-health-statistics/oecd-health-data-health-status_data-00540-en. (Accessed November 28, 2013).

24 Organisation for Economic Co-operation and Development, "Health at a Glance 2011," 2011, http://www.oecd.org/els/health-systems/49105858.pdf (accessed March 25, 2013).

25 Organisation for Economic Co-operation and Development, "Health at a Glance 2011," Special note on "Why Is Health Spending in the United States So High?" 2011.

26 Kristof Stremikis, Cathy Schoen, and Ashley-Kay Fryer, "A Call for Change: The 2011 Commonwealth Fund Survey of Public Views of the U.S. Health System," The Commonwealth Fund, 2011, http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Apr/1492_Stremikis_public_views_2011_survey_ib.pdf (accessed March 21, 2013).

27 Mark Smith et al., eds., *Best Care at Lowest Cost: The Path to Continuously Learning Health Care in America* (Washington, DC: National Academy of Sciences, 2012), http://www.nap.edu/catalog.php?record_id=13444 (accessed April 10, 2013).

28 David Goodman et al., "The Revolving Door: A Report on U.S. Hospital Readmissions," The Robert Wood Johnson Foundation, February 2013, http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf404178 (accessed April 10, 2013).

29 Pierre Yong, Robert S. Saunders, and LeighAnne Olsen, eds., "Excess Administrative Costs," in *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary* (Washington, DC: The National Academies Press, 2010), 141–74, https://download.nap.edu/openbook.php?record_id=12750&page=131 (accessed March 22, 2013).

30 Roseanna Sommers et al., "Focus Groups Highlight That Many Patients Object to Clinicians' Focusing on Costs," *Health Affairs* 32, no. 2 (2013): 338–46.

31 Jill Yeglan et al., "Engaged Patients Will Need Comparative Physician-Level Quality Data and Information About Their Out-of-Pocket Costs," *Health Affairs* 32, no. 2 (2013): 328–37.

32 Judith Hibbard et al., "An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care," *Health Affairs* 31, no. 3 (2012): 560–8.

33 Jill Yeglan et al., 2013.

34 U.S. Department of Labor, Bureau of Labor Statistics, "National Compensation Survey 2011," http://www.bls.gov/ncs/ebs (accessed March 25, 2013).

35 Catalyst for Payment Reform, "Improving Fee-for-Service Payment," 2012, http://www.catalyzepaymentreform.org/images/documents/CPR_Action_Brief__ImprovingFFS.pdf (accessed April 11, 2013).

36 Pierre Yong, Robert S. Saunders, and LeighAnne Olsen, eds., "Excess Administrative Costs."

37 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, "Chronic Disease Prevention and Health Promotion," http://www.cdc.gov/chronicdisease/index.htm (accessed March 26, 2013).

38 Ross DeVol and Armen Bedroussian, "An Unhealthy America: The Economic Burden of Chronic Disease—Charting a New Course to Save Lives and Increase Productivity and Economic Growth," The Milken Institute, October 2007, http://www.milkeninstitute.org/pdf/chronic_disease_report.pdf (accessed March 26, 2013).

39 Eric A. Finkelstein, Justin G. Trogdon, Joel W. Cohen and William Dietz, "Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates," *Health Affairs* 28, no. 5 (2009): s822–31.

40 Organisation for Economic Co-operation and Development, "OECD Health Date 2012," 2012.

41 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, "Overweight and Obesity," http://www.cdc.gov/obesity/index.html (accessed March 26, 2013).

42 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, "Progress on Childhood Obesity," *Vital Signs*, August 2013, http://www.cdc.gov/VitalSigns/pdf/2013-08-vitalsigns.pdf (accessed September 9, 2013).

43 Personal communication with Patricia M. Lynch, vice president of Government Relations for Kaiser Permanente, providing a compendium of studies showing the benefits of walking and exercise, March 26, 2013.

44 Gerald Riley and James Lubitz, "Long-Term Trends in Medicare Payments in the Last Year of Life," *Health Services Research*, February 2010, http://dx.doi.org/10.1111%2Fj.1475-6773.2010.01082.x (accessed March 28, 2013).

45 Samuel Marshall, Kathleen M. McGarry, and Jonathan S. Skinner, "The Risk of Out-of-Pocket Health Care Expenditure at End of Life," NBER Working Paper, 2010, National Bureau of Economic Research, http://www.nber.org/papers/w16170 (accessed April 11, 2013).

46 The Dartmouth Atlas of Health Care, "End-of-Life Care," http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2944 (accessed March 26, 2013).

47 David Goodman, Amos R. Esty, Elliott S. Fisher, and Chiang-Hua Chang, "Trends and Variation in End-of-Life Care for Medicare Beneficiaries with Severe Chronic Illness," *The Dartmouth Atlas Project,* The Dartmouth Institute for Health Policy and Clinical Practice, April 12, 2011, http://www.dartmouthatlas.org/downloads/reports/EOL_Trend_Report_0411.pdf (accessed October 26, 2013).

48 Amy Kelley et al., "Hospice Enrollment Saves Money for Medicare and Improves Care Quality Across a Number of Different Lengths-of-Stay," *Health Affairs* 32, no. 3 (2013): 552–61.

49 American Hospital Association, "Trendwatch Chartbook 2013," 2013, http://www.aha.org/research/reports/tw/chartbook/index.shtml (accessed April 9, 2013).

50 Paul Ginsburg, "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," Center for Studying Health System Change, *Research Brief* no. 16 (November 2010): 1–11.

51 Attorney General Martha Coakley, "Examination of Health Care Cost Trends and Cost Drivers," Office of the Attorney General of Massachusetts, March 16, 2010, http://www.mass.gov/ago/doing-business-in-massachusetts/health-care/health-care-forms-and-publications.html (accessed April 24, 2013).

52 Robert Murray and Suzanne Delbanco, "Provider Market Power in the U.S. Health Care Industry: Assessing Its Impact and Looking Ahead," Catalyst for Payment Reform, November 2012.

53 Anthony Shih et al., "Organizing the U.S. Health Care Delivery System for High Performance," Commission on a High Performance Health System, The Commonwealth Fund, August 2008, http://www.commonwealthfund.org/usr_doc/Shih_organizingushltcaredeliverysys_1155.pdf (accessed April 3, 2013).

54 Douglas McCarthy and Kimberly Mueller, "Organizing for Higher Performance: Case Studies of Organized Delivery Systems," The Commonwealth Fund, July 2009, http://www.commonwealthfund.org/Publications/Case-Studies/2009/Jul/Organizing-for-Higher-Performance-Case-Studies-of-Organized-Delivery-Systems.aspx (accessed April 5, 2013).

55 J. Michael McWilliams et al., "Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated with a Commercial ACO Contract," *JAMA* 310, no. 8 (2013): 829–36.

56 U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. "Medicare Shared Savings Program ACO Fast Facts," May 2013, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ACO-Fast-Facts.html. (accessed September 11, 2013).

57 David Muhlestein, "Continued Growth of Public and Private Accountable Care Organizations," *Health Affairs* blog, February 19, 2013, http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations (accessed April 22, 2013).

58 Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision, as of September 3, 2013," *State Health Facts*, September 3, 2013, http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act (accessed September 11, 2013).

59 John Holahan et al., "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," The Kaiser Commission on Medicaid and the Uninsured, The Kaiser Family Foundation, November 2012, http://kff.org/health-reform/report/the-cost-and-coverage-implications-of-the (accessed April 2, 2013).

60 Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2013 to 2023," February 5, 2013, http://cbo.gov/publication/43907 (accessed April 21, 2013).

61 Congressional Budget Office, February 5, 2013.

62 The Kaiser Family Foundation, "Medicaid Enrollment as a Percent of the Total Population, 2010," http://www.statehealthfacts.org/comparetable.jsp?ind=199&cat=4&sub=52&yr=92&typ=2&sort=a. (accessed November 28, 2013).

63 U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "MACStats: Medicaid and CHIP Program Statistics," March 2013, http://www.macpac.gov/macstats (accessed April 16, 2013).

64 U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "National Health Expenditures by Type of Service and Source of Funds, CY 1960–2011," National Health Expenditure Accounts, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (accessed April 15, 2013).

65 U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "NHE Historical and Projections, 1965–2021," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html (accessed May 7, 2013).

66 U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Medicaid Managed Care Enrollment Report," July 1, 2011, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf (accessed April 15, 2013).

67 Medicaid and CHIP Payment and Access Commission (MACPAC), "Report to the Congress: The Evolution of Managed Care in Medicaid," June 2011, http://www.macpac.gov/reports (accessed April 15, 2013).

68 Ellen Bayer, "Innovations in Medicaid Managed Care: Highlights of Health Plans' Programs to Improve the Health and Well-Being of Medicaid Beneficiaries," AHIP Center for Policy Research, March 2013, http://www.ahip.org/MedicaidInnovationsBook (accessed October 26, 2013).

69 United States Census, "Government Employment & Payroll," 2011, http://www.census.gov/govs/apes (accessed April 16, 2013); U.S. Department of Labor, Bureau of Labor Statistics, "Recent Data on Health Benefits from the National Compensation Survey," 2011, http://www.bls.gov/ncs/ebs/smb_health.htm (accessed April 16, 2013).

70 Sharon Silow-Carroll and Tanya Alteras, "Value-Driven Health Care Purchasing: Case Study of Wisconsin's Department of Employee Trust Funds," The Commonwealth Fund, August 2007, http://www.commonwealthfund.org/Publications/Fund-Reports/2007/Aug/Value-Driven-Health-Care-Purchasing--Four-States-that-Are-Ahead-of-the-Curve.aspx (accessed April 16, 2013).

71 Wisconsin Department of Employee Trust Funds, "It's Your Choice: 2013 Decision Guide," 2013, http://etf.wi.gov/publications/IYC-2013/et-2107d.pdf (accessed April 16, 2013).

72 Kaiser Family Foundation, "Establishing Health Insurance Exchanges: An Overview of State Efforts," March 2013, http://www.kff.org/healthreform/upload/8213-02.pdf (accessed April 17, 2013).

73 Sara Rosenbaum, Nancy Lopez, Taylor Burke, and Mark Dorley, "State Health Insurance Exchange Laws: The First Generation," The Commonwealth Fund Issue Brief, July 2012, http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Jul/1616_Rosenbaum_state_hlt_ins_exchange_laws_ib.pdf (accessed April 17, 2013).

74 National Conference of State Legislatures, "State Approval of Health Insurance Rate Increases," January 2013, http://www.ncsl.org/issues-research/health/health-insurance-rate-approval-disapproval.aspx (accessed April 17, 2013).

75 Kaiser Family Foundation, "Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable," December 2010, http://www.kff.org/healthreform/upload/8122.pdf (accessed April 17, 2013).

76 Victoria Bunce, "Health Insurance Mandates in the States 2012," Council for Affordable Health Insurance, 2013, http://www.cahi.org/cahi_contents/resources/pdf/Mandatesinthestates2012Execsumm.pdf (accessed July 23, 2013).

77 National Conference of State Legislatures, "State Health Insurance Mandates and the ACA Essential Benefits Provisions," June 2013, http://www.ncsl.org/issues-research/health/state-ins-mandates-and-aca-essential-benefits.aspx (accessed October 10, 2013).

78 Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Cost* (Washington, DC: National Academies Press, 2011), http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx (accessed July 23, 2013).

79 Amanda Cassidy, "Essential Health Benefits," Health Policy Brief, *Health Affairs*, Robert Wood Johnson Foundation, May 2, 2013, http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_91.pdf (accessed July 23, 2013).

80 Chris Pope, "The Perils of Health-Care Federalism," *National Affairs*, Summer 2013, no. 16 (2013).

81 Institute of Medicine, *The Future of Nursing: Leading Change, Advancing Health* (Washington, DC: The National Academies Press, 2011). http://www.nap.edu/catalog.php?record_id=12956#toc (accessed April 18, 2013).

82 Maria Schiff, "The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care," National Governors Association, December 2012, http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf (accessed April 19, 2013).

83 National Conference of State Legislatures, "Scope of Practice Overview," March 2013, http://www.ncsl.org/issues-research/health/scope-of-practice-overview.aspx (accessed April 18, 2013).

84 Robert Murray, "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience," *Health Affairs* 28, no. 5 (2009): 1395–405.

85 J. E. McDonough, "Tracking the Demise of State Hospital Rate Setting," *Health Affairs* 16, no. 1 (1997): 142–9.

86 This section used contributions from Allie Yudt, student of Ray Scheppach, from a memo provided to Dr. Scheppach.

87 George J. Annas, "Doctors, Patients, and Lawyers—Two Centuries of Health Law," *The New England Journal of Medicine* 367 (2012): 445–50.

88 Anupam B. Jena, Seth Seabury, Darius Lakdawalla, and Amitabh Chandra, "Malpractice Risk According to Physician Specialty," *The New England Journal of Medicine* 365 (2011): 629–36. http://www.nejm.org/doi/pdf/10.1056/NEJMsa1012370 (accessed October 26, 2013).

89 Douglas W. Elmendorf, "Effects of Proposals to Limit Costs Related to Medical Malpractice," Congressional Budget Office, October 9, 2009.

90 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care," 2003.

91 Michelle Mello, Amitabh Chandra, Atul A. Gawande, and David M. Studdert, "National Costs of the Medical Liability System," *Health Affairs* 29, no. 9 (2010): 1569–76.

92 National Conference of State Legislatures, "Medical Liability/Medical Malpractice Laws," August 15, 2011, http://www.ncsl.org/issues-research/banking/medical-liability-medical-malpractice-laws.aspx (accessed April 19, 2013).

93 Rebecca Maine and Margo Hoyler, "New Directions in Liability Reform," *Bulletin of the American College of Surgeons,* March 2, 2013, http://bulletin.facs.org/2013/03/new-directions (accessed September 12, 2013).

94 Shane Durkin and Erin Buchanan, "Medical Malpractice Reform: An Alliance for Health Reform Toolkit," Alliance for Health Reform, Robert Wood Johnson Foundation, August 7, 2013, http://www.allhealth.org/publications/Medical-Malpractice-Toolkit_151.pdf (accessed September 12, 2013).

95 Michelle Mello, Allen Kachalia, Sarah Goodell, "Medical Malpractice—Update," The Synthesis Project, Robert Wood Johnson Foundation, April 2011, http://www.rwjf.org/content/dam/farm/reports/reports/2011/rwjf70017 (accessed April 19, 2013).

96 Emily Carrier, James D. Reschovsky, David A. Katz, and Michelle M. Mello, "High Physician Concern About Malpractice Risk Predicts More Aggressive Diagnostic Testing in Office-Based Practice," *Health Affairs* 32, no. 8 (2013): 1383–91.

97 Scott B. Murray, "Buyers and Sellers Beware—Federal and State Antitrust Authorities Heighten Scrutiny of Healthcare Provider M&A," The Metropolitan Corporate Counsel, March 22, 2012, http://www.metrocorpcounsel.com/articles/18385/buyers-and-sellers-beware-%E2%80%93-federal-and-state-antitrust-authorities-heighten-scrutiny (accessed April 18, 2013).

98 All Payer Claims Database Council, "All-Payer Claims Database (APCD) Fact Sheet," APCD Council Web site, 2010, http://www.apcdcouncil.org (accessed April 18, 2013).

99 Catalyst for Payment Reform, "Report Card on State Price Transparency Laws," March 18, 2013, http://www.catalyzepaymentreform.org/images/documents/reportcard.pdf (accessed April 17, 2013).

100 Amy Winterfeld, Douglas Shinkle, and Larry Morandi, "Promoting Healthy Communities and Preventing Childhood Obesity: Trends in Recent Legislation," National Conference of State Legislatures, February 2010, http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf57963 (accessed October 26, 2013).

101 Trust for America's Health, "F as in Fat: How Obesity Threatens America's Future 2012," September 2012, http://www.healthyamericans.org/report/100 (accessed April 23, 2013).

102 Alena Hadley et al., "What Works for the Prevention and Treatment of Obesity Among Children: Lessons from Experimental Evaluations of Programs and Interventions," Child Trends, March 2010, http://www.childtrends.org/wp-content/uploads/2013/03/Child_Trends_2010_03_25_FS_WWObesity.pdf, (accessed December 2, 2013).

103 Ruth S. M. Chan and Jean Woo, "Prevention of Overweight and Obesity: How Effective Is the Current Public Health Approach," *International Journal of Environmental Research and Public Health* 7 (2010): 765–83, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2872299/pdf/ijerph-07-00765.pdf (accessed April 24, 2013).

104 Robert Mechanic, Stuart H. Altman, and John E. McDonough, "The New Era of Payment Reform, Spending Targets, and Cost Containment in Massachusetts: Early Lessons for the Nation," *Health Affairs* 31, no. 10 (2012): 2334–42, http://healthforum.brandeis.edu/publications/pdf/Mechanic.Altman.Oct.2012.HIF.Site.Version.pdf (accessed October 26, 2013).

105 Kaiser Family Foundation, "Massachusetts Health Care Reform: Six Years Later," May 2012, http://www.kff.org/healthreform/upload/8311.pdf (accessed April 24, 2013).

106 Nikki Guilford, "Tools and Techniques of Effective Governors," National Governors Association, May 2010, http://www.nga.org/files/live/sites/NGA/files/pdf/1009OMCTTOOLSTECHNIQUES.PDF (accessed May 7, 2013).

107 Office of the Governor, State of California, Let's Get Healthy California Task Force, "Let's Get Healthy California Task Force Final Report," December 19, 2012, http://www.chhs.ca.gov/Pages/HealthCalTaskforce.aspx (accessed September 16, 2013).

108 Christine Bechtel and Debra L. Ness, "If You Build It, Will They Come? Designing Truly Patient-Centered Health Care," *Health Affairs* 29, no. 5 (2010): 914–20, http://content.healthaffairs.org/content/29/5/914.full.pdf (accessed October 26, 2013).

109 RTI International, "Accountable Care Organization 2012 Program Analysis: Quality Performance Standards Narrative Measure Specifications," Report to the Centers for Medicare & Medicaid Services, December 12, 2011, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_QualityMeasures.pdf (accessed May 22, 2013).

110 ACO Business News, "ACO Development in Exchanges, Medicaid Slows as States Await Decisions on ACA," *Atlantic Information Services* 4, no. 1 (2013).

111 Teresa Coughlin, Timothy Waidmann, and Lokendra Phadera, "The Diversity of Dual Eligible Beneficiaries: An Examination of Services and Spending for People Eligible for Both Medicaid and Medicare," Kaiser Family Foundation, April 2012, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7895-02.pdf (accessed October 26, 2013).

112 Jenna Walls et al., "Two-Thirds of States Integrating Medicare and Medicaid Services for Dual Eligibles," AARP, April 2013, http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/states-integrating-medicare-and-medicaid-AARP-ppi-health.pdf (accessed October 26, 2013).

113 Kaiser Family Foundation, "Comprehensive Medicaid Managed Care Activity for Dual Eligibles," State Health Facts, 2010, http://kff.org/medicaid/state-indicator/managed-care-activity-for-dual-eligibles (accessed May 24, 2013).

114 Alice Dembner, "Putting Consumers First: Promising Practices for Medicaid Long Term Services and Supports," Community Catalyst, November 2012, http://www.communitycatalyst.org/doc_store/publications/putting_consumers_first_LTSSmanagedcare.pdf (accessed October 26, 2013).

115 Maura Calsyn, "Toward an Effective Health Insurance Exchange: A Roadmap to Successful Health Care Reform," Center for American Progress, June 2012, http://www.americanprogress.org/wp-content/uploads/issues/2012/06/pdf/health_exchange.pdf (accessed May 22, 2013).

116 Executive Office for Administration and Finance, Mass.gov Web site, "Health Policy Commission Initiates First Cost & Market Impact Review," Press Release, May 22, 2013, http://www.mass.gov/anf/press-releases/hpc/hpc-initiates-first-cost-and-market-impact-review-.html (accessed October 16, 2013).

117 Chris Pope, "The Perils of Health-Care Federalism," *National Affairs* no. 16 (2013).

118 National Council of State Boards of Nursing Web site, Nurse Licensure Compact, https://www.ncsbn.org/nlc.htm (accessed September 16, 2013).

119 Oklahoma Turning Point Council Web site, "Certified Healthy Programs," 2013, http://www.okturningpoint.org/index.html (accessed August 4, 2013).

120 Office of the Governor of Mississippi, "Hundreds Gather for Second 'Governor Phil Bryant's 5K Run for Health," Press Release, http://www.governorbryant.com/hundreds-gather-for-second-governor-phil-bryants-5k-run-for-health (accessed August 4, 2013).

121 Iowa Governor's Council on Physical Fitness and Nutrition Web site, 2013, http://www.healthyiowa.gov/default.aspx (accessed August 4, 2013).

122 Columbia University Mailman School of Public Health, "Obesity Drops Among Children Enrolled in NY State WIC Nutrition Program," Press Release, January 8, 2013, http://www.mailman.columbia.edu/news/obesity-drops-among-children-enrolled-ny-state-wic-nutrition-program (accessed October 17, 2013).

123 Amy Winterfeld, Douglas Shinkle, and Larry Morandi, February 2010.

124 Soeren Mattke et al., "Workplace Wellness Programs Study," Research Report, The RAND Corporation, 2013, http://www.rand.org/pubs/research_reports/RR254.html (accessed August 5, 2013).

125 The State of New Hampshire Employee Wellness Program Web site, http://admin.state.nh.us/wellness (accessed August 5, 2013).

126 National Conference of State Legislatures, "State Employee Health Benefits," August 2013, http://www.ncsl.org/issues-research/health/state-employee-health-benefits-ncsl.aspx#Wellness (accessed October 13, 2013).

127 Alabama State Employee Insurance Board Web site, http://www.alseib.org/Default.aspx (accessed August 5, 2013).

128 Soeren Mattke et al., 2013.

129 Maureen Bisognano and Ellen Goodman, "Engaging Patients and Their Loved Ones in the Ultimate Conversation," *Health Affairs* 32, no. 2 (2013): 203–6.

130 Amy Kelley et al., "Hospice Enrollment Saves Money for Medicare and Improves Care Quality Across a Number of Different Lengths-of-Stay," *Health Affairs* 32, no. 3 (2013): 552–61.; National Hospice and Palliative Care Organization, "Hospice Care in America," 2012, http://www.nhpco.org/sites/default/files/public/Statistics_Research/2012_Facts_Figures.pdf (accessed June 3, 2013); Albert J. Finestone and Gail Inderwies, "Death and Dying in the U.S.: The Barriers to the Benefits of Palliative and Hospice Care," *Clinical Interventions in Aging* 3, no. 3 (2008): 595–9, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2682390/pdf/CIA-3-595.pdf (accessed June 3, 2013).

131 Amy Kelley et al., March 2013.

132 Charles Sabatino and Naomi Karp, "Improving Advanced Illness Care: The Evolution of State POLST Programs," AARP Public Policy Institute, April 2013, http://assets.aarp.org/rgcenter/ppi/cons-prot/POLST-Report-04-11.pdf (accessed August 5, 2013).

133 MaryBeth Musumeci, "Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS," Kaiser Family Foundation, September 30, 2013, http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared (accessed October 18, 2013).

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