Containing Health Care Costs: Recent Progress and Remaining Challenges

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Chairman Murray, Ranking Member Sessions, other distinguished Members of this Committee, it is an honor and a privilege to have been invited to offer my thoughts on health care cost growth containment for your consideration. You do have a daunting task, to shape public policy toward our vital public insurance programs, our health system generally, and our nations' key priorities through your budget making, including balancing our commitments to the most vulnerable among us with sound fiscal prudence, so that we may honor commitments made over time.

My name is Len M. Nichols. I am a health economist, Professor of Health Policy, and Director of the Center for Health Policy Research and Ethics in the College of Health and Human Services at George Mason University in Fairfax, Virginia. I conduct research about and help create public-private partnerships to pursue incentive realignments that can sustain a more efficient, effective, and humane health care system. I am an advisor to the Virginia Center for Health Innovation[1] and to the Patient Centered Primary Care Collaborative,[2] two organizations committed to improving the health systems of Virginia and the nation, respectively. I am also on the governing boards of the National Committee on Quality Assurance[3] and Academy Health,[4] and am a member of the National Committee on Vital Health Statistics.[5] I do want to make clear though that my written testimony and spoken views are mine and mine alone.

I organize my remarks around two key contextual questions and then address the most important challenges before us.

Question #1: Is the recent health care cost growth reduction real?

Though reform opponents do not like it much, there is little doubt that health care cost growth has been slowing lately. Rarely have important facts been so difficult to push to their proper

[1] http://www.vahealthinnovation.org/
[2] http://www.pcpcc.org/
[3] http://www.ncqa.org
[4] http://www.academyhealth.org
[5] http://www.ncvhs.hhs.gov

central place in the public mind. The Office of the Actuary (OACT) at the Center for Medicare & Medicaid Services (CMS), with expertise that spans health economics, actuarial science, and financial accounting, has long been our nation's official arbiter of health spending levels and trends. Table 1 is an excerpt from their most recent report on historical health care spending, per capita.

Table 1: Growth per capita, compared to the prior year

	1990	2000	2007	2008	2009	2010	2011
NHE	9.9	5.5	6.6	3.7	3.0	3.1	3.1
GDP	6.6	4.4	4.1	0.9	-3.1	2.9	3.2

NHE = national health expenditures; GDP = gross domestic product. Source: Hartman et al,[6]

Clearly, health care cost growth per person has been much lower lately than its historical record of growing 2.6 percentage points faster than GDP per capita since 1960.[7] Importantly, even as the economy has recovered from the Great Recession in 2010 and 2011, health care growth relative to GDP has held steady. Equivalent growth rates in health costs and national income per capita is a good definition of a sustainable health system.

These trends are reflected in public insurance program growth rates as well. Table 2 is also excerpted from the recent OACT report.

[6] Hartman, M., et al. "National Health Spending in 2011: Overall Growth Remains Low, but Some Payers and Services Show Signs of Acceleration," *Health Affairs* 32(1):87-99 (Jan 2013).
[7] Kaiser Family Foundation, "Assessing the Effects of the Economy on the Recent Slowdown in Health Spending," http://www.kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/

Table 2: Growth rates, compared to the prior year

	2005	2006	2007	2008	2009	2010	2011
Medicare	9.2	18.8	7.4	8.0	6.9	4.3	6.2
Enrollment	1.8	2.0	2.1	2.6	2.4	2.5	2.5
Per enrollee	7.2	16.5	5.1	5.3	4.3	1.8	3.6
Medicaid	6.4	-0.9	6.3	5.8	8.8	5.9	2.5
Enrollment	2.9	-0.6	0.1	3.5	7.3	4.9	3.2
Per enrollee	3.4	-0.3	6.2	2.2	1.4	1.0	-0.7

Source: Hartman, M., et al, see note 6.

There is no question that health care cost growth has recently slowed broadly across the health care system.

Question #2: Can the recent health cost growth slowdown be sustained?

This question has become the subject of considerable commentary, as well it should. It really matters. The Congressional Budget Office, another group of non-partisan analysts with crucial expertise and standing, has lowered their estimate of federal Medicare and Medicaid costs for 2020 by 15% from what they had forecast three years ago, just as the Patient Protection and Affordable Care Act (ACA) was passed. For Medicare alone, that equates to nearly $400 billion lower projected spending over the next seven years.[8] If these trends continue to 2022, public sector health spending could be over $750 billion lower than recent projections.[9] As this committee knows, that would represent serious progress toward a sustainable federal fiscal structure.

The main argument advanced by pessimists (who are also typically ideological or at least political opponents of health reform) is that the health spending slowdown is an artifact of the reduction in demand for care that inevitably accompanies job and coverage losses in a recession and thus will disappear as the recovery continues to pick up steam. The first major empirical

[8] Cutler, D. and Sahni, N. "The Forecast Slowdown in Medicare Spending: Is More Coming?" *Journal of the American Medical Association Forum* 2/21/13, http://newsatjama.jama.com/jama-forum-the-forecast-slowdown-in-medicare-spending-is-more-coming?/

[9] Cutler, D. and Sahni, N. "If Slow Rate of Health Care Spending Growth Persists, Projections May Be Off by $770 Billion," *Health Affairs* 32(5):841-850 (May 2013).

hole in that argument was established in 2012 when Roehrig and colleagues at the Center for Sustainable Health Spending of the Altarum Institute[10] showed that the health cost growth slowdown pre-dated the recession's onset by two or more years.[11] (The slowdown also pre-dates the ACA). This issue is sufficiently important to state the obvious: if cost growth reductions preceded the recession, then the recession cannot have been the major cause of recent cost growth reductions. The second major empirical hole in the pessimists' argument was provided by the Medicare data of Table 2. Why and how exactly would the recession lead Medicare beneficiaries, whose benefits have not been reduced, to lessen their demand for care enough to lower spending growth per enrollee?

This is not to suggest that our long struggle with health cost growth in the US is over. And that judgment, shared by virtually all serious analysts of our health care system, has led to a number of recent important analyses of factors that might explain patterns in health spending growth, with particular emphasis on the recent slowdown. These studies are different and important enough to understand where and why they differ, and how they should be interpreted in their totality.

The first one was published by the Kaiser Family Foundation in collaboration with the Altarum economists and systems engineers. That study's authors developed a model that can "explain" 77% of health care spending growth solely with variables that measure general (economy-wide) inflation, lagged inflation, GDP growth, and lagged GDP growth. The fundamental contribution of the paper was to show that the effect of GDP on health spending occurs with as much as a 5-year lag, and that the lagged effects are much larger, cumulatively, than the statistical effects of current GDP. Since the cost-growth slowdown clearly occurred before the recession it cannot have been primarily caused by the recession, and the model predicts that lingering dampening effects of the (lagged) recession on demand for health services will last for a while but will be counterbalanced as the economy continues to recover. The authors conclude that "Increases in health expenditures are likely to trend upwards over the coming decade as the economy returns

[10] http://altarum.org/cshs

[11] Roerhig, C., et al. "When the Cost Curve Bent: Pre-Recession Moderation in Health Care Spending," *New England Journal of Medicine* 367(7) (August 16,2012).

to a more normal rate of growth."[12] This is surely true, if nothing else matters to health system cost growth.

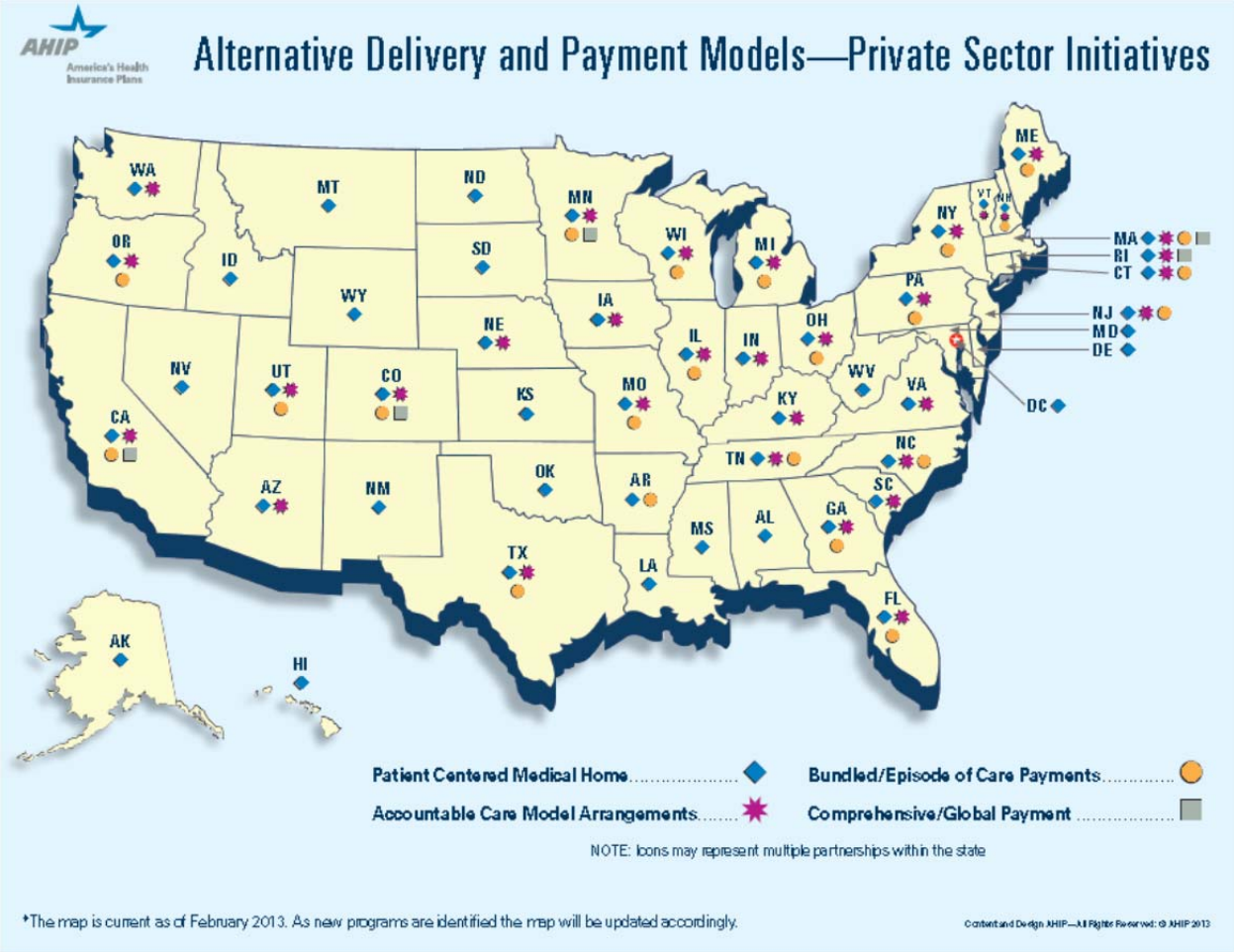
Two other peer-reviewed studies take more traditional approaches of isolating the impact of GDP growth (or job losses) while controlling for health system impacts like Medicare payment policy (which changed substantially in the ACA), changes in insurance coverage, and benefit generosity.[13] They conclude that the economy alone explains at most a third of health spending growth reductions in recent years. These results combined with the Kaiser study suggest that other, possibly structural factors are also at work lowering cost growth rates in the health care system. The authors infer from various data points that slower technological advance (more generic drugs, slower adoption or use rate of new diagnostic technologies, etc.) and greater efficiencies in hospitals have and may continue to contribute to health cost slowdowns.

There is thus a consensus that the economy affects health care spending growth, but so do health policy and general market trends in the health care sector. Therefore, a return to robust economic growth does not mean we are doomed to repeat our health care cost growth past. It all depends on whether forces in the system now that dampen cost growth are stronger than forces in the system – including recovering demand – that increase cost growth, as they have been these last two years.

I am personally and professionally optimistic that cost growth lower than long run trend *could* be maintained, because of the illustrative examples I am about to describe (briefly), which add to up to one overarching reality: private and public payers are developing congruent incentive structures for clinicians and hospitals, frequently in tandem, that have the potential to link the self-interest of all major health system stakeholders with the social interest in cost growth containment, quality improvement, and better health for our population (the triple aim).[14] To see this congruence vividly, look at the following map, which we can call Figure 1.

[12] Cf. note 7.
[13] Cutler and Sahni, cf. note 9; Ryu, A., et al. "The Slowdown in Health Care Spending in 2009-11 Reflected Factors Other Than the Weak Economy and Thus May Persist," *Health Affairs* 32(5):835-840 (May 2013).
[14] Berwick, D., et al. "The Triple Aim: Care, Health, and Cost," *Health Affairs* 27(3):759-769 (May/June 2008).

Figure 1.



This map is maintained and regularly updated by America's Health Insurance Plans, and is available from its website.[15] Each symbol represents examples of patient centered medical homes, bundled payments, accountable care arrangements, or comprehensive global payments, designed and implemented by private plans with willing provider partners, but similar in spirit and detail to the demonstration projects underway at the Center for Medicare and Medicaid Innovation (CMMI) pursuant to the ACA. The larger point is that in every state in the union payment reforms and incentive realignments are taking place outside the government program that reinforce the care transformation objectives of current public policy. Coupled with the extensive array of CMMI initiatives,[16] the US health care system has not seen this much change

[15] http://www.ahip.org/

[16] http://innovation.cms.gov/. One of my co-panelists today, Dr. Kavita Patel of the Brookings Institution, will discuss selected CMMI initiatives in some detail, so I will not, except in response to questions at the hearing or afterward.

oriented around incentive realignments since Medicare switched from cost-based hospital reimbursement to diagnosis-based prospective payments in the early 1980s. If you remember the award-winning movie about the Von Trapp family, *The Sound of Music*, a good metaphor for the US health care system today is the opening sweeping panorama followed by the crescendo of Julie Andrews' voice singing "The Hills are Alive" with the sound of care process redesigns and incentive changes designed to make better outcomes sustainable at lower total cost.

This alignment of public and private goals – made possible by the ACA and the private contracting innovations that preceded and have followed it – is by far the most humane way to get the health spending portion of our long-run budget priorities where it needs to be. The alternative to incentive realignment is draconian benefit and price cuts, which would be income-based rationing in reality if not in euphemistic name. Severe cuts are also wholly unnecessary if we choose to support and nurture those already on the path to a better aligned American health system that is within our imagination and our grasp.

The examples I will describe deliberately exclude the many exemplary integrated systems of care, for though they are beacons in more ways than one, we have to make our health system work in all places, including where for various reasons fully integrated systems – like Group Health Cooperative and Virginia Mason Medical Center in Seattle, Intermountain Health Care in Salt Lake City, Geisinger Health System in Danville, Pennsylvania, the Baylor Health System in Dallas, Kaiser Permanente in Oakland, San Francisco, Los Angeles, Denver, Maryland, Northern Virginia and DC, etc., – simply will not come to be anytime soon, if ever.

The first promising example I will cite is the Alternative Quality Contract (AQC) implemented in 2009 by Blue Cross and Blue Shield of Massachusetts. That arrangement is essentially a global budget with willing provider groups that are rewarded for their quality and cost performance. They also bear financial risk and reap rewards if they do well. Hallmarks of this arrangement include a multi-year contract, technical and data support by the plan, and incentives tied to explicit quality metrics (roughly similar to those used by Medicare ACOs) as well as to reductions in the total cost of care of enrolled patients, even if some of the care is delivered by providers not covered by the AQC. Participating provider groups include large multi-specialty medical practices, small physician groups, and large physician-hospital organizations. Peer reviewed and published results for the first two years' performance indicate that costs were

reduced (1.9% in year one, 3.3% in year two) while quality increased, and the results were larger for groups that were in the AQC longer.[17] This makes perfect sense since care innovations to improve care coordination and communication among teams of providers, patients with complex needs and their families – the essence of what payment reform is trying to incentivize – take time to implement and require adjustments by all concerned. The really good news is this program is expanding and now has 1,600 primary care physicians and 3,200 specialists involved.

Two more non-profit Blues' plans' innovations that are designed to advance the goals of the triple aim while meeting providers where they are on the ground are worthy of note, partly because they are in very different places, California vs. the Chesapeake region (Maryland, DC, and Virginia).

In 2009 Blue Shield of California (BSCA) signed an ACO-like arrangement with the Hill Physicians' Medical group (a large IPA with 3,800 affiliated physicians) and with the hospital system Dignity Health (formerly Catholic Healthcare West) that uses a global budget for a designated set (41,000) of California Public Employees Retirement System (CalPERS) enrollees living in or near Sacramento, California. As in the AQC, providers can share in savings if they materialize and if quality targets are met. CalPERS was given an immediate "rebate" for these enrollees of $15.5 million, consistent with holding premium cost growth to zero, and this in turn both required and incentivized the plan, hospital system and physician group to cooperate so that they could save more than that to break even. In the first year, according to an internal analysis conducted for BSCA by Milliman, the Blue Shield ACO saved $20.5 million, so $5 million was distributed among the partners. Year two results were even better for all concerned, saving $22 million more for CalPERS and $8 million more for the partners. Blue Shield has now expanded the program to seven more ACO-like arrangements serving 90,000 more enrollees.[18]

CareFirst, the Blue Cross and Blue Shield plan in the mid-Atlantic region serving Maryland, DC, and northern Virginia, launched a very ambitious patient centered medical home program in

[17] Song, Z. et al, "The 'Alternative Quality Contract,' Based on a Global Budget, Lowered Medical Spending and Improved Quality," *Health Affairs* 31(8): 1885-94 (Aug 2012).
[18] Markovic, P. "A Global Budget Pilot Project Among Provider Partners and Blue Shield of California Led to Savings in the First Two Years," *Health Affairs* 31(9):1969-76 (Sept 2012).

2011.[19] Early results are promising, the more so because the mid-Atlantic region, unlike California and Boston, has not had a history of care coordination and large multi-specialty groups (which are typically in a better position than small physician practices to adapt care processes to better manage the relatively seriously chronically ill). The CareFirst design is tailored to make it easy for previously isolated small practices to join the program, by supplying an information and care coordination infrastructure to facilitate participating practices' focus on the right patients, providing an upfront increase in FFS payment rates for participating in the program, and for sharing savings according to cost and quality performance but with *no* downside risk to the primary care physicians. As a consequence of these features, over 80% of CareFirst participating primary care providers (PCPs) have joined the program, until by now, nearly 3,600 PCPs treating over 1 million commercial (non-Medicare) patients are involved. According to internal CareFirst calculations and analyses, the program, net of PCP bonuses, saved CareFirst 1.5% total expected expenditure on (voluntarily) participating enrollees in year one and 2.7% in year two.[20] Even before formal external evaluation results have been compiled, CareFirst is confident enough to expand the program to the Medicare population, and recently secured a CMMI grant and negotiated a cooperative agreement to do just that.

Creative experiments in this vein are not confined to the private sector. Since 2006, 26 state Medicaid programs have also enabled and encouraged primary care practices to begin functioning as medical homes for Medicaid enrollees, through new or revised payment systems and reporting requirements.[21] Indeed, Medicaid has been central to some key multi-payer initiatives of the CMMI, including the multi-payer advanced primary care practice demonstration and the comprehensive primary care initiative, which have engendered support and participation of over 3000 PCPs in 15 states .[22]

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[19] In the interests of full disclosure, I am the Principal Investigator of a 5-year evaluation of CareFirst's PCMH program, leading a team centered at George Mason University. Two other evaluation teams, centered at Harvard and Westat, Inc., respectively, have also been retained by CareFirst to conduct independent evaluations of their program. All formal evaluations are just getting under way, so the results referenced in my testimony are from Care First's internal calculations and assessments that have been released to the public.

[20] CareFirst press releases. "CareFirst BlueCross Blue Shield Announces First Year Patient Centered Medical Home Results, June 7, 2012; "Patient Centered Medical Home Program Trims Expected Health Care Costs by $98 Million in Second Year," June 6, 2013.

[21] Takach, M "About Half of the States are Implementing Patient Centered Medical Homes for Their Medicaid Populations," *Health Affairs* 31(11):2432-2440 (Nov 2012).

[22] http://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Frequently-Asked-Questions.pdf

A noteworthy and recent version of multi-payer payment reform was the Colorado Multi-payer Patient Centered Medical Home pilot coordinated by HealthTeamWorks, which ran from 2009-2012, and included 16 small physician practices and seven health plans including United, Aetna, Cigna, Anthem-Wellpoint, Humana, CoverColorado (the state's high risk pool carrier) and Medicaid. Formal evaluation results have not yet been published, but preliminary findings indicate that the pilot significantly reduced emergency department visits and hospital admissions.[23] In addition, most participating practices moved right into Colorado's successful application and implementation of the Comprehensive Primary Care Initiative of CMMI. The most useful part of this pilot may have been the wealth of lessons learned they have passed on to others, including how to (and how not to) sort through thorny data and payment change issues in multi-payer settings, especially when self-insured employers have control and (sometimes) less knowledge about new payment and incentive models' promise. Change takes time and concerted effort on multiple fronts, i.e., it is *not* easy, even though the potential payoff is large.

Which brings me to what I think are the seven most important challenges to sustained cost growth reduction across our health care system. Three are more political than policy-specific, but precisely because of that you on this committee and in this Senate can do something about all of them, if you so choose.

Challenge #1: Excess partisanship

All politics is partly and unavoidably partisan, but surely we have set new records lately. The sad truth is our current state of partisanship mostly serves to divert focus from how the reform law and implementation process should and could be improved. Democrats are afraid to admit the law has flaws and Republicans are afraid to admit the law has some really good ideas and provisions, and just might work as advertised in some states. In addition, it appears to me that Republicans have no consensus among themselves for a viable alternative to the ACA, for if they did would they not have proposed and passed it in 2001-2006 when they controlled the White House and the Congress? To move forward toward solidifying cost growth reduction, which I know both parties support, the charade of repeal and de-funding should stop and all of you

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[23] Harbrecht M. and Latta, L. "Colorado's Patient Centered Medical Home Pilot Has Met Numerous Obstacles, Yet Saw Results Such As Reduced Hospital Admissions," *Health Affairs* 31(9):2010-2017 (Sept 2012).

should get on with the serious business of working together to improve the existing law of the land so that more of our people will be better served.

Some traditional Republican ideas that have more support on the Democratic side – and in the health system – than may be well-known include: malpractice reform; more state flexibility (like Arkansas is undertaking through a waiver); and a budget failsafe which would reassure people who fear the long term budget consequences of the ACA by linking coverage expansion and generosity with savings performance and financing alternatives. But these and a host of other legitimate design and implementation issues cannot be addressed under constant threat of total repeal. There is a long and distinguished tradition of bipartisanship on this and on the Finance Committee on which some of you also serve, and in the Senate generally,[24] and our country and the legitimate pursuit of bipartisan health policy to support cost growth containment would be well-served if you could help resurrect that tradition sooner rather than later.

Challenge #2: Tell the American people the truth.

It is stunning to me how hard it is in the present day to move facts and logic to their proper places in the public mind. The truth is we can solve our current fiscal woes without abandoning our commitment to our most vulnerable citizens and to ourselves. Health care cost growth, our most serious long-run fiscal problem, *is* coming down and will stay down if we are smart and disciplined about it, and encourage and spread the kinds of programs and models I described above. This is not to say every payment model or application of it has to work or the whole enterprise of health reform is doomed to saddle our children with unbearable debt. We can learn a lot from failures and mixed successes, indeed, we rarely learn enough any other way. Our country is large and diverse, and we will surely need different models in different parts of it, to reflect our differing values, if nothing else. Proponents of reform are asking extremely hard working and dedicated health professionals to effectively re-design the airplane they are flying without landing the plane, because patients keep coming every second of every day, and we cannot change our payment and information systems overnight. But the evidence is clearly building that we can achieve the triple aim in many cases and the number of those cases is

[24] Nichols, L. "Government Intervention in Health Care Markets is Practical, Necessary, and Morally Sound," *Journal of Law, Medicine and Ethics,* Fall 2012.

expanding every day, if we but free our imaginations and creativities (a bit more on this last point later) to pursue what is possible.

Furthermore, we are the least taxed advanced nation on the planet. Our federal and state governments take ***TEN PERCENTAGE POINTS*** less of our GDP than the OECD average, and we have a larger military than all of them combined. The idea that our economy cannot tolerate reasonable tax increases and keep growing robustly is contradicted by so much evidence I do not know where to begin. We may yet *choose* to keep taxes below what they would have to be to support a decent social safety net in an aging society that must also invest in children and economic infrastructure and peace in a complex world, but that would still be a choice, not a necessity, and the debate should be more properly framed and conducted that way.

Challenge #3: Be honest about what it costs to take care of the poor.

Why do hospital associations uniformly support taking advantage of the Medicaid expansion provision in the ACA? Because they have to contend with our implicit but unstated policy of forcing them to partially make up for our collective Medicaid underpayment – and what it takes to take care of the uninsured – by charging private payers more than it costs to take care of their patients. We do this because we would apparently rather force hospitals to levy this implicit tax out of the public eye than to have an honest discussion about what it really costs to take care of the poor and what we are and are not willing to pay for that.

Well, you might have heard this rumor, but private employers are tired of paying this implicit tax because their own health care costs too much even before the surcharge. Furthermore, hospitals know they have to become more efficient and invest in information systems and care coordination infrastructures that will enable them to thrive in the emerging payment environment, but they cannot invest to become more efficient when they have to spend so much energy and resources on the under- and uninsured.

Interestingly, state chambers of commerce, like the one in Virginia, have done the math and have publicly endorsed the Medicaid expansion along with the local hospital association because the evidence is overwhelming that it would be good for the fiscal situation of the state government, good for the economy of the state, good for the local health care system, and good for the people of Virginia. They, and courageous governors like the ones in Arizona, Ohio, Florida, Nevada

and New Mexico have laid down their ideological opposition to the ACA and taken up the quest to have a more honest discussion about costs and benefits and priorities. Surely this discussion would be more widespread and impactful if the Senate Budget Committee started exploring the implications of Medicaid expansion vs. not in an intellectually rigorous environment, focused perhaps on economic and budget impacts. This would enable more public officials to deal more openly with the twin truths that Medicaid "costs too much" and that we pay less than it costs to treat the poor (under current sub-optimal care coordination conditions) in virtually every state in the nation.

Challenge #4: Enable clinicians to lead the transformation we need.

A major difference in the health care system today compared to 20 years ago, and possibly a reason the ACA passed and the Clinton Health Security Act did not, is that *way* more physicians, nurse leaders, hospital and health plan executives now know and admit we have to reform our health care system because our society and our people increasingly cannot afford the system we have built. Many are quite eager to help re-shape it, but they are frustrated by many roadblocks which make the status quo seem like the only operational model, flawed though it is. In my view, all have essential parts to play, but physicians need to be in the front of the reform bus, not in the back.

For them to take the driver's seat, you must first remove the two major diversions that keep them from focusing completely on the task at hand: malpractice reform and repeal of the SGR. I don't really care how, just do it. You would in those two strokes engender tremendous good will in the essential physician community. And I'm sure you know, SGR reform is at an all-time bargain basement price right now, because of recent cost growth trends. Malpractice reform is more complicated, but not beyond your capacities, I am quite confident.

Next, for physicians to lead in system and incentive redesign, they have to have access to total cost of care data. I have cited examples of health plans willing to share total cost of care and quality data, and in some cases, to build information and care coordination infrastructures to support better physician and patient choices. Unfortunately, not all health plans are similarly enlightened about sharing data, and in some cases the only way to ensure that clinicians and even

employer-payers have access to total cost of care data is through legally compelled all payer claims data bases (APCDs). Twelve states have those now. I would encourage you to give the other 38 states powerful incentives to follow suit within a very short time frame. Markets cannot work without transparent cost, price and quality data and signals. They never have, and they never will. We should give health markets the tools they need, over the objections of those who profit from our ignorance today.

By the way, at the moment only three of those APCDs include Medicare data, yet Medicare is almost always the single more important buyer of health care services for many providers. This raises a general point about enabling Medicare to become more of a partner in private system reform. Some current law and internal interpretations of current law restrict CMS' ability to partner in ways that current and recent leadership (going back at least to the first President Bush) would like. Medicare beneficiaries and taxpayers, and therefore the program, will surely gain if the entire health care system becomes more efficient through appropriate data sharing. CMS has recently taken welcome steps in this regard (the release of MEDPAR hospital and physician pricing data is a salient a case in point), but many will acknowledge it could do much more. So I urge you to examine ways Medicare in particular and CMS in general could aid the cause of system redesign but is hampered today by statute, regulation, internal interpretation, or overly parsimonious administrative support budgets.

In my view, CMMI overall has done a good job of launching many experiments we needed to test for delivery and payment reform. But given the urgency of the problem, amplified by the centrality of health care cost growth to our current budget debates, something more on the order of the Manhattan project may be in order. Like the project that developed an American atomic bomb before the Germans got one near the end of WWII, we really cannot afford to fail here. The Health Care Innovation Challenge grant program (applications for round 2 of which are due August 15) is a creative way to tap the spirit of innovation in the private sector, but a more systematic sampling of private sector opinions, priorities and perceived impediments, including a frank discussion of why CMS is sometimes perceived as less than an ideal research partner today, could take the delivery and payment reform effort to a whole new level, where it needs to be, at least until more people are more confident that we have truly bent the cost curve for at least a generation. This probably needs to happen at the Secretarial level, or at least at the level

of the CMS Administrator, for the proper focus to be brought to bear. The absolute key to bending the curve, in my opinion, is implementing realigned incentives that link clinician self-interest to the social interest in the triple aim, with a special emphasis on cost containment, since if we cannot afford access and quality, we cannot sustain them. Clinicians must be involved in those incentive design discussions, and to do that all must share all relevant data.

Challenge #5: Acknowledge that some local market power must be countered.

I and others have written on this topic for years,[25] but the reality is that some plan, hospital, and physician service markets are not very competitive today, and when that is the case, it is impossible for market forces alone to drive us to the efficient state we need to reach. Antitrust law and policy can be helpful in some cases, but typically, at least in its current forms, antitrust is a rather blunt instrument not well suited for the fluid subtleties of evolving health service market competition and collaboration. As an economist, I am reluctant to "give up" and recommend unit price regulation when we have yet to seriously try price transparency and domestic medical tourism (some health plans now pay for travel to a center of excellence that is also typically cheaper than the local monopolist), but an openness to rate regulation as a last resort should probably be in our cost containment arsenal as well.

Challenge #6: Engaging consumers and patients

We have to overcome our fear of telling consumers and patients that they have a huge and essential role to play in their own health and in enabling our system to afford good care for all. In my view the administration missed a major opportunity in the original ACO regulation by not enabling participating provider organizations to at least offer a positive incentive (a "carrot" like reduced Part B premium) to remain with the organization for a year. Signaling such a willingness to engage consumers would have made many providers much more comfortable about moving to a world in which their payment levels will be determined in part by how compliant patients are with their recommended regimens. Honest discussions of personal responsibility for health choices and financial responsibility could also help bridge some of our partisan divides. We have to be careful about it, of course, but if we do not get consumers

[25] Nichols, L., et al. "Are Market Forces Strong Enough To Delivery Efficient Health Care Systems? Confidence is Waning," *Health Affairs* 23(2):8-21 (March/April 2004).

appropriately engaged, we are unlikely to be as successful in reducing costs as we need to be. Charging more in premiums for smoking and less for participation in wellness programs, as the ACA permits, is a good start, but enabling medical homes and ACOs to offer incentives for sticking with them and penalties for going "out of network" would also add useful tools and send appropriate "we are all in this together" signals at a critical time.

Challenge # 7:Focus health policy more on communities and less on either the nation as a whole or on the individual states.

Health care markets, like political markets, are ultimately local. In my experience these last few years of talking about health reform in virtually every state in the union, red, blue and purple, communities are the one geographic area where most people today are capable of putting aside their politics and focusing on what needs to be done to make their own health care system work where they live and work and play and pray. HHS and some states have done an amazing job lately making local data more available and user friendly than ever before, and I applaud them for that. I'm proud to say that the National Committee for Vital Health Statistics on which I serve has been learning to listen to communities and has produced reports about how communities are using data to promote local health improvements consistent with their own priorities.[26] I can think of no better example of democracy in action than that.[27]

Yet I have also learned that despite all the recent efforts, many communities have far more questions than answers, and often lack basic capacity to organize and use the data they do have in productive local conversations with all relevant stakeholders. Part of the barrier is the absence of cost data, and so I will refer back to the APCD discussion above. But I would sincerely urge you to ask HHS to think creatively and expansively about how to use existing governmental data and resources to empower communities to lead conversations about the health and health system improvements they want, rather than the ones well-intentioned reformers might imagine they want or should want, given the way the data look to experts. In the end, our political system is based on the principle that the people are the experts who matter most, at least about what they

[26] National Committee for Vital Health Statistics, *The Community as a Learning System: Using Local Data to Improve Local Health* http://www.ncvhs.hhs.gov/111213chip.pdf

[27] San Diego has done inspirational and translatable work in this area. http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/CHS-EconomicBurdenofChronicDisease2010.pdf

want that government may or may not be able to facilitate. We should think more often about how government can help people inform and empower themselves.

I thank you again for the opportunity to share thoughts with you today on our health care cost growth realities and prospects, and I would be glad to answer any questions my testimony may have engendered.