

“Health Care Reform for the American Dream”

Structural Reforms for Inclusion, Innovation, and Value

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Health Care Reform for the American Dream

The promise of being healthy, and also being able to see the best doctors in the world, either for preventative care or should illness arise, is an important part of our identity as a nation. America is rightfully proud of our medical community. We have outstanding physicians, superior medical schools, and top-notch research institutions and pharmaceutical companies that lead the world in innovation and medical technology. However, not every American can afford the promise of health care. Hope Street Group believes that every American should be able to have access to basic affordable, quality health care, and that American values of inclusion and innovation should be present in our health care system. We believe that true health care reform would be universal, affordable, and portable, and would promote a uniquely American system that would allow households and businesses to gain more choice and predictability in the cost and quality of the health care services they purchase, while embracing medical innovations that improve the quality of our lives.

Unfortunately, we are far from that goal today. There are currently 46 million uninsured and 16 million underinsured Americans, and our existing system constrains social mobility and entrepreneurship by locking tens of millions more people with pre-existing medical conditions into their current jobs for fear of losing health care benefits. Our system makes it harder for small businesses to attract the talent they need to innovate and expand. It also creates unpredictable cost pressures on U.S. corporations, which stifles competitiveness and creates job losses in major U.S. industries. The rising cost of health care is one of the biggest factors suppressing the take-home pay of American workers, particularly for moderate-income families. Health care disparities also have a negative impact on economic opportunity. According to Hope Street Group's Economic Opportunity Index, 13% of the economic opportunity disparity between males and females is due to social safety nets and health outcomes, both of which are better for men. These findings highlight the importance of productivity during crucial working years of an individual's lifetime because even though women tend to live longer than men, men enjoy greater productivity during their working years (due to a number of reasons Hope Street Group is investigating, including workforce interruptions caused in many women's lives due to childbirth).¹ Finally, health care costs are the biggest source of budgetary pressure on state and federal governments. As costs balloon, reforming our health care system to be more affordable and equitable is essential to restoring our nation's fiscal strength, as well as to increasing the average family's take-home pay and savings.

Many other American industries have consistently led the world in both innovation and productivity, and our health care system shouldn't be any different. Over time, a uniquely American system of health care that leverages competition and the best of medical science should be able to deliver superior health outcomes, universal coverage, and more innovation than single-payer systems, and it should be able to do so at comparable levels of costs as a proportion of national income. Our national goal should be to achieve that superior cost effectiveness with universal access within 20 years. By slowing the rate of growth of health care costs from 7-8% to 5-6% annually, we could free up roughly \$2.7 trillion in resources (at today's dollars) for our families, our businesses, and our public services over the next decade, for an overall savings of \$700-800 billion by 2020.

Accomplishing these twin goals of providing universal coverage and controlling costs will require government, employers, families, and health care institutions to enact radical structural reforms.

Shifting the Debate: Coverage, Choice, Quality, and Trust

Resources are not the problem. As Americans, we spend extraordinary amounts on our health care system, but we do not spend efficiently: Americans are no healthier than our counterparts in Europe or Japan. The health care system as a whole is inefficient, draining \$500-700 billion of resources each year from families, businesses, and taxpayers.² Meanwhile, it would cost roughly \$70-\$303 billion annually to provide those currently uninsured with a basic but comprehensive health

insurance plan.³ And while the U.S. health care industry has been an engine of medical innovation for the entire world, even it is sputtering due to dramatically rising costs of drug and device R&D.

Incentives are the problem. Our current health care system – from R&D to financing to purchasing to marketing to health care delivery in hospitals and clinics – is overrun with misaligned incentives that increase health care costs or profits, but not necessarily better health outcomes. These bad incentives are due to a mix of over-regulation, under-regulation, and the ad-hoc and diffuse nature of the system that has evolved over time. The uninsured skip preventive and chronic disease care but then are treated too late in high-cost emergency rooms. About 20% of the uninsured (vs. 3% of those with coverage) use emergency rooms as their primary source of care.⁴ Hospitals charge employers and insured patients what they can't collect from Medicare, Medicaid, and the uninsured, which in turn causes some employers to reduce coverage for their employees.⁵ High-income employees of large companies receive a tax subsidy on components of their health plans, while the self-employed have no access to large insurance risk pools, tax advantages, or buying power. A doctor who diagnoses and heals a patient effectively in fewer visits receives lower reimbursement than one who does so more slowly (or not at all) in more visits. Medical equipment manufacturers market imaging machines as profit-generating investments to physicians, who then order their patients over twice as many MRIs as physicians who don't own machines.⁶ In some cases, doctors order more tests and procedures than they believe are required to avoid malpractice lawsuits.

Pharmaceutical companies spend 7-15 years and an estimated \$1.2 billion to develop a new drug, close to 6 times what it cost in 1987.⁷ These risks of increased time and costs are causing a gradual shift in R&D portfolios from the transformational therapies that can dramatically improve health outcomes, toward “me-too” drugs for which incremental demand is generated through aggressive marketing to doctors and to consumers. Patients accept or even seek tests or procedures they don't need – despite the health risks of over-treatment – because they lack objective information about both what truly works and who provides the best care. All of these individuals and institutions are operating within the rules of our current system to gain profits and reduce risk. The problem is that illness and treatment, not better health and superior efficiency, drive the financial engines of the health care system.

Root cause reforms are essential. As a result, our current system is structured so that essential American values of inclusion and innovation are virtually impossible to sustain at acceptable long-term costs. It would cost \$70-\$303 billion annually⁸ to provide basic universal coverage to all uninsured Americans, an amount that is low enough to persuade most people – even those who do fine in the status quo – that it is a worthwhile endeavor. Without structural reform, however, at the current rates of health care inflation the cost of universal coverage will double each decade, accelerating the fiscal meltdown of our health care system.⁹ Similarly, many believe that future innovations in personalized medicine, genomics, advanced diagnostics, trauma care, and chronic disease treatments would become tremendously expensive, further eroding health care coverage.

Structural reform is essential to realize sustainable inclusion and innovation. However, such reforms will be very difficult to achieve politically, for four reasons: (1) the hundreds of billions of dollars in excess system costs represent somebody's profits, job or career, or point of accessing the system; (2) the needed structural reforms will create uncertainty for health care institutions and constituencies about how their current investments, infrastructure, and practices will fare in a new system; (3) we lack the public infrastructure and much of the private infrastructure to support significant reform; and (4) many voting Americans, who more or less like their current coverage and care, hesitate to embrace changes that seem to put them at risk.

In order for structural reforms to have a chance to succeed politically and operationally, they must: (1) be sufficiently deep and broad to generate real and visible improvements in cost and quality over

time; (2) gain the trust of consumers by reassuring them they have a choice; (3) provide some tangible (and intangible) benefits to each of the major constituencies in the current system, to offset their “losses” that costs savings represent; (4) be phased in over a multi-year timetable to enable existing institutions to adapt their strategies and practices to the new, better incentives. By implication, such structural reforms will need to be achieved as part of a negotiated, multi-phase reform package in which universal health care coverage would be part of the first phase, thus putting “new money” into the health system as one major source of offsetting benefits.

Universal coverage and bold structural reforms can transform the system

Given the resources we already spend, comprehensive health care reform should have the following goals:

- provide universal comprehensive health care coverage to all Americans;
- preserve innovation;
- improve quality;
- ensure a healthier country with a higher life expectancy and quality of life; and
- reduce the rate of our spending to be in step with that of other wealthy and healthy countries over the next 20 years.

Achieving these goals will require some significant changes in the behavior of all stakeholders, including health care providers, suppliers of pharmaceuticals and devices, insurers, CMS and state Medicaid agencies, employers, and patients. Such radical transformation will also require a careful combination of policies, including some additional mandates, some elimination of burdens, and a far greater alignment of information and incentives to cost-effective medical practices. Most important, changes must be viewed as building on the best of what our system offers today, not as starting from scratch.

Achieving Universal Coverage. Hope Street Group supports a plan for universal coverage that includes the following principles:

- **Universal Eligibility:** a comprehensive level of benefits for which all Americans will be eligible¹⁰
- **Competition:** multiple private health plans can compete to offer these basic plans (without limitations due to pre-existing medical conditions) as well as plans with additional features or benefits for which individuals can pay additional premiums and/or co-pays
- **Limited Tax Benefits for Employers:** employers can still choose to administer their own plans, but the tax benefits for employer plans would be no greater than for individuals or for plans sponsored by affinity groups such as unions, religious organizations, or other associations
- **Individual Choice:** individuals can choose to sign up for a plan of their choosing, including one that would be similar to the federal employee plan
- **Employer Options:** employers can choose to avoid the administrative complexity and cost volatility of offering their own health coverage by instead contributing a fixed percentage of the cost of the base plan per employee (like they do for Social Security)
- **Mandate to be Insured:** there would be an individual requirement to be insured, with subsidies for those who cannot afford it
- **Portability:** continuity for those who change or lose their jobs regardless of health status
- **Limited Out-of-Pocket Expenses:** there would be reasonable limits on the out-of-pocket health costs that a family would have to pay in a given year with sliding scale government subsidies to those with limited means.

There are several proposals for universal health care coverage which contain a number of these elements in different permutations, and the details of achieving universal coverage (e.g., exactly what is covered in the base plan, what is the employer contribution %, what is the re-insurance role of government to guarantee access for those with pre-existing conditions, etc.) will ultimately come down to extensive analysis, debate, and negotiation. However, universal access to true insurance (inclusion) with multiple health plans (innovation and choice) and an unbiased tax treatment of health spending (incentives) are essential elements of coverage reform.

Structural reforms of health care delivery and intermediation. In order to make health care spending sustainable in the context of universal coverage, we must tackle other deep rooted structural and regulatory reforms, including reducing inefficiencies and wasteful spending, improving quality and increasing accountability of the players in the system. Some valuable steps would include using health information technology to reduce medical errors, having federally-funded programs use evidence-based disease management and care coordination services, and using reward and reimbursement strategies that emphasize high quality care.

To reach the goal of permanently funding universal health coverage while improving health outcomes and reducing costs for ordinary families, businesses, local, state and federal governments, we need to tackle some of the major misalignments in incentives.

Each of the following five reforms should generate approximately \$20 billion or more in health system savings if instituted appropriately. Given the time necessary to implement them, many of these changes should be phased in over a period of several years. In the aggregate, they can exceed the goal of reducing health care inflation by 2 points over the next decade. Nothing less than structural reform on this scale will be required to achieve the productive, innovative, and inclusive American health care system our country deserves.

1. ***Increase physician focus on quality medicine, remove conflicts of interest, and reduce costs and risks for physicians who practice good medicine.*** [Estimated cost/value impact: >\$20-40 billion¹¹ annually.]
 - **Create an independent comparative effectiveness group/authority that systematically collects, measures, evaluates, and publishes data on quality outcomes, quality improvements, and compliance with evidence-based guidelines.** This group should offer recommendations that serve as the basis for both private and public sector coverage decisions, reimbursement, and medical standard-of-care. Many common episodes (e.g., a bout of pneumonia or a year's worth of diabetes treatment) have evidence-based guidelines for treatment that are established by the medical profession.¹² This group should create a database of common episodes for defining treatment and measure compliance with guidelines established by the medical professional societies. Risk-adjusted results should be published and data shared with practitioners as the basis for quality improvement and reimbursement, with continuous review of the methodology. CMS can drive many of these changes by making public their own physician-identified, patient de-identified data and agreeing to a common measurement system for federal programs. Also, CMS and commercial payers must be allowed to drop physicians from their network and not to pay for common avoidance errors and illnesses caused by infection rates above acceptable levels.
 - **A concerted effort to improve quality driven by the private sector should be supported by the public sector through the use of incentives.** CMS must lead the way in pay for performance and should support a common standard for transporting medical records in a safe, secure single format. Technologies, including electronic health records, which provide for collaborative electronic consultations,

automated prescribing, and the measurement and provision of standard, high-quality medicine should also be supported.

- **Eliminate self-referral by physicians and incentives to use popular devices or procedures.** In a fee-for-service reimbursement environment, physicians with a financial equity stake in an imaging facility refer patients for MRIs twice as often as physicians without such a financial interest. The same is true for other tests and specialist procedures (e.g., CT and PET scans, clinical lab tests, specialty hospital referrals, high-cost treatments such as chemotherapy), and such incentives appear to drive at least \$20 billion in excessive costs or procedures each year.¹³ The Council on Ethical and Judicial Affairs of the American Medical Association has concluded that such conflicts of interest violate medical ethics.¹⁴ Medical groups should be required either to sell their financial stakes in fee-for-service specialty facilities or to convert them fully to per-episode reimbursement basis.
- **Reform the medical malpractice system by offering physicians indemnification for those who demonstrably follow evidence-based standards in return for adhering to comparative effectiveness-derived guidelines and accepting changes in reimbursement.** This removes an incentive for physicians to perform medically unnecessary procedures on a “defensive basis.”¹⁵ Malpractice insurance companies should be given access to this public data and be allowed to differentiate insurance premiums based on evidence of following evidence-based care guidelines.

2. *Align reimbursements to quality, not quantity, and higher value of care.*

[Estimated cost/value impact: High impact expected.] In the current system, almost all providers of health care are reimbursed by procedure or on a cost-plus basis. Outstanding researchers of the U.S. medical profession have defined evidence-based clinical practices for the most common and most expensive conditions, and yet health care providers generally receive no financial benefit by (and are often penalized financially for) following cost-effective practices. Variation of care is so widespread that every effort needs to be made to make guidelines public where possible and create incentives for their use.¹⁶ In addition, effective care during disease episodes includes quality measures that go beyond the current typical scope of provider reimbursement, such as emails, telephone calls, and home visits.

- **Change reimbursement through rapid cycle experimentation and then implementation so that it is based on compliance with best scientific methods and quality improvement.** Without transferring financial risk to providers, physicians should be reimbursed based on the care provided in an entire episode of treatment of a patient. The level of reimbursements would be driven by the provision of adequate preventative care, referrals to specialists and delivery systems who provide evidence-based care, and the coordination of care and follow-up. Defining treatment by episodes for both acute events and chronic conditions is the first essential step to paying for best practices. Much existing technology and consensus on guidelines already exists. An open process, in which evidence-based care protocols defined by independent medical experts (and already collected by Agency for Healthcare Research and Quality, AHRQ) are the starting point, should achieve consensus definitions for episodes representing 70-80% of health care costs, and should set a research agenda for others. Also, rapid cycle experimentation and then implementation of alternatives could include “medical homes,” global fees (combined hospital and physician), episodes, warranties, risk-sharing, and forms of capitation. This change should also be driven by CMS, in part by migrating from Resource-Based Relative Value Scale (RBRVS) to payments per episode.

- **Pay bonuses for superior health outcomes and quality improvement.** As population based outcomes are collected and measured longitudinally, annual bonuses should be paid for acuity-adjusted processes, outcomes, and quality improvements. Here again, CMS must lead the way.
- 3. *Realign pharmaceutical and device industry incentives and regulation towards innovation.*** [Estimated cost/value impact: >\$28-53 billion annually.¹⁷]
- **Restrict direct marketing to doctors and consumers.** Pharmaceutical and device companies spend in excess of \$28-\$58 billion annually¹⁸ marketing to doctors and consumers, often influencing practice patterns independent of evidence. Restrict pharmaceutical companies and others with financial interests from directly advertising or promoting products in an office setting directly to physicians, and limit it in formal educational setting, such as for CME credit. Pharmacists and physicians should be trained and given tools to educate patients on the benefits and risks of medicines and devices. Incentives for practicing the best medicine should assist physicians in this role. By restricting direct-to-consumer (DTC) marketing, pharmaceutical companies will see reduced exposure to lawsuits alleging misleading claims and can reduce Selling, General, and Administrative (SG&A) expenses associated with drug development and marketing.
 - **Reduce the time and risk associated with the development of new drugs.** The cost and time of bringing a new drug from development to market should be reduced through a reformed clinical trial and FDA application process by using a system of “Learn and Confirm” cycles teamed with extensive statistical analysis during drug clinical trials to increase understanding of the data with potentially faster approval, but without reducing safety.¹⁹ This process will increase the identification of drugs with efficacy and reduce the number of costly failed Phase 3 trials, thus reducing the number of drugs that reach the market with serious side effects not picked up during the pre-approval clinical trials. Also, fewer patients will be needed for initial trials, which also will decrease costs. And as risks also are reduced through better post-market data and oversight, new drug applications can increase and prices decrease. “Learn and Confirm” already is being used by some companies.²⁰
 - **Promote medication compliance.** Low patient compliance is a major cause of poor health outcomes. As part of reimbursement for value, physician offices and pharmacists should be compensated in part for better communication of the benefits of treatment, which results in higher patient compliance levels for drugs prescribed in accordance with evidence-based guidelines, creating significant new demand for therapies with proven track records of cost effectiveness.²¹
 - **Evaluate patent incentives for development of new drugs and devices that significantly reduce disease.** Assess patent life for new drugs and devices based upon the economic value the drug is providing based on longitudinal outcome reviews. If drugs are developed which eliminate significant cardiovascular disease or cure Alzheimer’s, such evidence can be used to extend the patent life of a drug by an additional 2 years. This idea requires more study – e.g., by the Institute of Medicine, or similarly respected body – but it would be of great value should it cause a shift in research portfolios towards transformational rather than “me too” drugs.
- 4. *Improve the efficiency of the role of private health plans.*** [Estimated cost/value impact: ~\$32 billion annually.²²] While Hope Street Group considers it essential to retain the innovation potential inherent in a multi-payer system, reforms of the current system, including universal coverage, can achieve significant savings through simplification and

standardization. A common administrative utility function, promoted by CMS, would allow many of these reforms to take hold:

- **Streamline underwriting costs.** Approximately 64 % (or \$32 billion) of administrative costs come from in underwriting and marketing costs.²³
- **Allow health plans to offer nationally certified plans** with basic coverage benefits that all states must accept (state-specific plans could still be offered, wherever state insurance commissions and health plans believe they create value).
- **Standardize benefit designs to configurable options.** Trying to compare coverage offered between plans should be considered easy, formulaic, and accessible for consumers and providers. Allow individuals or companies to buy increased coverage levels, using a common configurable approach so that total payments and co-payments can be easily calculated.
- **Standardize claims formats and standards** and make medical policy rules a transparent part of the claims submission process, both to improve quality and to reduce cost and errors among private health plans.
- **Publish the claim denial rates and claim resubmission rates of each health plan for consumers and physicians to review.** Allow regulators to revoke insurance and administration licenses from plans with unacceptable levels of denials or claims rework.

5. *Improve the management of health and seek to decrease long-term demand for the health care system.* [Estimated cost/value impact: High in the long term] Here government, by acting through agencies like CMS, could lead the health care industry and have a big impact.

- **Require the use of chronic disease management for Medicare and Medicaid patients with major chronic diseases.** Many leading causes of death and poor health – e.g., heart disease, lung, breast, and prostate cancer, diabetes - are all illnesses that are often preventable or treatable with early detection. Proven effective disease management services should be a mandated benefit of all programs receiving federal funding.
- **Launch a national health and wellness initiative**, which would both raise awareness and educate the public about nutrition and physical fitness, important and effective means of improving physical health and well-being. Programs should include improving diet through food policies, increasing exercise by integrating with education programs, and coordinating prevention programs across public and private entities.
- **Promote childhood health education, in particular around obesity, coverage of health management, counseling, and nutritionist services.** The current health care system places insufficient emphasis on healthy lifestyle interventions needed to decrease morbidity and mortality from major illnesses and to curb the epidemic of obesity that grips our nation. Individuals have a personal responsibility to work toward healthy lifestyles, maximizing the benefit of medical interventions they do have and preventing unnecessary complications of chronic illnesses and aging. Education in healthy lifestyle decisions should start early: schools should offer mandatory health education to increase health literacy, and provide healthy, balanced food options (e.g., produce from local farmers markets).
- **Make preventive care benefits part of the standard.** All plans influenced by government (e.g., nationally certified health plans) must include basic primary and preventative care based on evidence-based standards.

Making the Case for Reform: Building on the Best of American Health Care

Efforts to create an inclusive, innovative, and cost effective health care system will be complex, because the distortions in today's system are complex. For change to be embraced, however, the message must be relatively simple, and the essence of the changes understandable. Moreover, while opposition to many aspects of reform will be intense, the overall approach must provide each stakeholder in our health care system a clear basis to compete in the new system as well as time to transition.

True health care reform will:

1. **Preserve the ideal of good medicine** by paying more and reducing the risks to physicians who practice better, cost-effective medicine, by limiting the influence of the profit motive on referral and treatment decisions, and by limiting the cost explosion that threatens employer coverage.
2. **Improve health care delivery** by giving physicians real-time information on better treatment, and the financial incentive to do so; by rewarding drug companies for finding breakthrough cures and treatments rather than marketing “me-too” drugs; and by rewarding successful innovations and productivity improvement in health care delivery, not just in medical science.
3. **Expand access** to the tens of millions of Americans whose current health coverage – or lack of coverage – does not allow them to participate in our health care system. Such reforms won't make employers stop offering health coverage, but it will ensure that patients have good alternatives if they do.

These reforms will get our health care system back on a sustainable path, paving the way for future breakthrough treatments and expansion of coverage (e.g., long-term care). Moreover, these reforms will save dollars for taxpayers, families, and businesses.

Implications for major health care stakeholders

Large Employers: *Large employers outside the health care industry should strongly support such reforms.*

- **Pros:** Reforms will make costs more predictable for the vast majority of employers who currently pay for health plans, addressing their biggest “pain point” today. Employers can still offer plans to their employees, using benefits as a way to attract top talent if they choose. Over time, as the new system develops, they can choose to opt out of health insurance administration, while still contributing financially; or they can choose to use their relationships with employees to drive healthier choices and reduce plan costs.
- **Cons:** Over time, the health care tax deduction will be capped or limited to the cost of basic health care plans. Those employers who do not offer minimally comprehensive plans to low wage employees today will need to contribute more to fund health care.

Small employers/Self-employed individuals: *Small businesses oppose pay-or-play mandates, but small business owners will benefit from lower coverage costs and equal tax treatment, while avoiding administration costs.*

- **Pros:** Following reforms, small businesses will be offered lower costs than offered currently for those who pay for employee health care plans. Reinsurance between insurance companies and prevention of denial of coverage based on pre-existing conditions will diversify the risk pools and give opportunity for individuals, small business owners, and small groups to get competitive rates on insurance coverage. Small businesses can choose not to administer plans. Individual entrepreneurs and small business owners will receive the

same tax treatment as large employers, and self-employed can choose to join an ‘affinity plan’ through trusted trade association or civic/community institution.

- **Cons:** Small businesses that do not provide coverage today will need to contribute to health care of employees (on a % basis of basic plan), and relatively high income self-employed who do not choose to purchase coverage will face an individual mandate.

Insurance companies & industry: *Insurance companies can thrive in the new system by changing their business models, but the adjustment will be significant; leading national insurers can become supporters.*

- **Pros:** Change in reimbursement norms will create new opportunities to reduce delivery costs, differentiate between best and lagging providers, and to profit from cost-effective care. Expanded coverage will increase enrollment, and nationally certified plans will reduce SG&A costs for national companies. Affiliate plans provide new market opportunities.
- **Cons:** These reforms will require change in the standard business model from underwriting/screening as a key profit lever (since they can no longer deny coverage based on pre-existing conditions), as well as substantial new investments in IT, systems, and skills. Many smaller insurance companies will be unable to make the transition, and so will oppose change. Also, lower administrative costs mean significant job losses in the industry, with fewer commission opportunities.

Physicians: *Reforms will meet with significant opposition from national and state medical associations and from doctor-entrepreneurs; generating support for evidence-based reform from quality-, ethics- and disease-focused professional bodies is critical.*

- **Pros:** Physicians will be rewarded for providing quality care and practicing better medicine (e.g., can make longer visits if that works best without losing money). There will be decreased administrative costs and complexity (once new reimbursement system is understood). Physicians will be indemnified from malpractice if they follow evidence-based guidelines. There will also be the opportunity to take financial stakes in integrated care groups to profit from using evidence-based practices in episode-based reimbursement model.
- **Cons:** These reforms mean increased scrutiny of the huge variations in practice patterns and the loss of ability to profit from fee-for-service self-referral. Physicians will also need to learn the new technology and reimbursement system. If physicians do not accept that the changes reflect the best insights of their profession and a chance to bolster medicine as a profession (vs. a business), then their opposition will be intense.

Delivery Systems (e.g., hospitals, outpatient networks): *For-profit hospital groups should welcome coverage expansion but will oppose cost reduction and data sharing provisions that allow payors to pay for best practices.*

- **Pros:** Hospital groups will be compensated for the burden of caring for individuals who are currently uninsured. Hospitals will have a path to greater reimbursements for improved quality. Groups will be responsible for reduced administrative expenses (once the transition to new reimbursement approaches is complete).
- **Cons:** Increased transparency of costs and performance will give more bargaining power to payors. Hospital groups could face significant transitional costs to implement new technology and reimbursement system.

Pharmaceutical and medical device companies: *Pharma and device companies will resist limits on marketing but will support streamlined drug development and increased demand from coverage and patient compliance.*

- **Pro:** Streamlined approval process to decrease time from bench to bedside, reduced marketing costs, and incentives for drug compliance, with greater protection from lawsuits, would increase demand for drugs and devices and lower pre-market costs. Reduced costs for introducing new drugs and devices, as well as expedited approval and increased use for the most effective and cost-efficient drugs will result in increased profits. Also, if modest patent extension was available for highest-impact therapies, it would be an enormous “carrot” for effective drugs and devices.
- **Cons:** If sales fall due to no DTC marketing bottom line will be adversely impacted. Companies would lose some marketing tools (e.g., physician detailing) that are central to their business models today (but they would also eliminate these costs, and it is a level playing field). Post-approval review following drug approval increases risk of drug being taken off the market after trial period. Companies will see price reductions due to group purchasing by public and private payers.

Timing of Implementation

Many reforms will require manageable implementation efforts and different time frames for different reforms.

- **Coverage reforms can be implemented within a two year period, with the goal of providing everyone coverage within two years.** Private sector vendors can put together bids to perform various services and market to individuals who would be required under an individual mandate to obtain coverage. State or regional pools should be formed and marketed to individuals while hospitals and clinics should be set up to reach out to patients as they show up without coverage.
- **Quality reforms should be adopted right away and implementation can begin within a year.** A Bureau of Health Statistics should be established to publish and disseminate usable data for quality evaluation.²⁴ This data would also be used to monitor drug safety and measure the outcomes of new medicines and population-based treatments. For-profit firms will build the applications and conduct and publish analysis in compliance with the standards set by CMS and the FDA.
- **System modifications necessary for payment reforms will need to be implemented over several years.** Claims systems and hospital systems will need to be modified. Standard benefits and reduced resubmissions should create a quicker capital payback. Tax incentives could be considered to spur investment in the required new systems.

Footnotes

¹ Hope Street Group Economic Opportunity Index (hopestreetgroup.org/eoi)

² McKinsey Global Institute (MGI), *Accounting for the Cost of Health Care in the United States* (January 2007), p. 78 & 10. \$500-700 billion in waste, and \$477 billion above Estimated Spending According to Wealth.

³ MGI report estimates that \$77 billion in 2003 (40 million uninsured) would cover the *uninsured* population. (MGI Report, p. 79)

Based on the cost of funding the uninsured in Massachusetts, we estimate more conservatively that funding the *uninsured* at a level comparable to Massachusetts (likely different demographics and more comprehensive coverage than covered by the estimate in the MGI report) would cost \$303 billion, based on the following analysis:

A. Total cost of initiative in Massachusetts: \$1.7 bn (“Mass. Has yet to collect fees from firms for healthcare,” Alice Dembner, *The Boston Globe*, May 10, 2007)

B. Number of uninsured to receive coverage: 263,000 (“Massachusetts Offers Details on Health Coverage,” Pam Belluck, *The New York Times*, April 12, 2007)

C. Annual cost per uninsured: ~\$6,464 (A divided by B) (cost spread across individuals, businesses, and government)

D. Total uninsured in the US: 46,994,627 (Kaiser Family Foundation; www.statehealthfacts.org)

D*C = \$303,767,550,950

⁴ Kaiser Family Foundation, *The Uninsured: A Primer, Key Facts About Americans Without Health Insurance* (January 2006).

⁵ The Kaiser Family Foundation concluded that health insurance premiums increase faster annually than inflation or wage increases. They observed more employers dropping employee health coverage during years of highest annual increases in premiums.

Kaiser Family Foundation and the Health Research and Educational Trust (2007).

Employer Health Benefits – 2007 Summary of Findings.

<http://www.kff.org/insurance/7672/upload/Summary-of-Findings-EHBS-2007.pdf>

⁶ MGI, p. 44, reference 15.

⁷ The data was reviewed in “United States: Healthcare Services: CROs,” December 3, 2007, Goldman Sachs Group, Inc.

⁸ See endnote 3 above.

⁹ Congressional Budget Office, “Technological Change and the Growth of Health Care Spending,” January 2008 pp. 12-13. Total spending on health care as share of GDP has nearly tripled over the last forty years. CBO projects the amount spent to reach 31% of GDP by 2035, which would be more than twice the amount spent in 2005.

¹⁰ States such as Oregon, Tennessee, and Massachusetts that have a range of basic coverage options can be used to determine basic coverage benefits.

¹¹ Analysis: >\$20 billion from self-referrals; up to \$20 billion from malpractice insurance; does not include cost/savings of collecting, measuring, and publishing quality data or improving quality through CMS leadership.

¹² National Guideline Clearinghouse has evidence-based clinical guidelines suggested for common diseases and treatment options: www.guidelines.gov. Online. Available. Accessed: February 20, 2008.

¹³ MGI report page 51, exhibits 31-32

¹⁴ Berlin L, and Berlin JW. “Leasing imaging facilities to referring physicians: fee shifting or fee splitting?” *Radiology*, Vol. 234 No. 1 (January 2005), pp. 44-48.

¹⁵ Cost of malpractice insurance is \$20 billion (MGI, p. 18).

¹⁶ Groups like Leapfrog and Bridges for Excellence have developed programs that give financial rewards to physicians for improvements in quality care. In Georgia, the Center for Health Transformation leads the nation’s largest Bridges to Excellence in diabetes program. Fourteen large employers, including UPS, BellSouth and others participate in the program and have estimated savings of \$1059 per individual if control measures of patients are met. In these programs, physicians are rewarded, individuals with diabetes are healthier, and employers save money. PacifiCare (based in California) has been a major group leading the way, reimbursing providers in part based on quality. Also, as an alternative approach, doctors at the Mayo Clinic are paid a fixed salary that is not based on the fee-for-service model. The providers are free to focus on high quality care and to collaborate as a team with other doctors.

¹⁷ Analysis: \$28-58 billion annually from direct marketing to doctors and consumers; not included is savings from drug development, cost/savings of medication compliance, or cost/savings of patent incentives.

¹⁸ Gagnon MA, Lexchin J. “The cost of pushing pills: a new estimate of pharmaceutical promotion expenditures in the United States.” *PLoS Med.* 2008 Jan 3;5(1):e1.

¹⁹ Sheiner LB. “Learning versus confirming in clinical drug development.” *Clin Pharmacol Ther.* 1997 Mar;61(3):275-91. Review.

Jonsson EN, Sheiner LB. “More efficient clinical trials through use of scientific model-based statistical tests.” *Clin Pharmacol Ther.* 2002 Dec;72(6):603-14.

²⁰ For example, Wyeth Pharmaceuticals uses “Learn and Confirm.” (www.wyeth.com/research/drugprocess)

²¹ Both pharmacy programs and improved physician communication with patients increase patient medical compliance, as seen in these sample studies:

Lee JK, Grace KA, Taylor AJ. “Effect of a pharmacy care program on medication adherence and persistence, blood pressure, and low-density lipoprotein cholesterol: a randomized controlled trial.” *JAMA.* 2006 Dec 6;296(21):2563-71. Epub 2006 Nov 13.

Young HN, Bell RA, Epstein RM, Feldman MD, Kravitz RL. “Types of information physicians provide when prescribing antidepressants.” *J Gen Intern Med.* 2006 Nov;21(11):1172-7.

Liang W, Kasman D, Wang JH, Yuan EH, Mandelblatt JS. “Communication between older women and physicians: preliminary implications for satisfaction and intention to have mammography.” *Patient Educ Couns.* 2006 Dec;64(1-3):387-92. Epub 2006 Jul 26.

²² Analysis: Up to \$32 billion can be saved annually from underwriting and marketing costs; not included is cost/savings of standardization of plans and forms.

²³ MGI report, pp. 73-74, exhibit 61 & 62.

²⁴ In 2007, New York state began a health care reform initiative that reviews health care spending and created “Partnership for Change,” which collects data and input to help advance access and control costs of high value health care. New York State 2008-2009 Executive Budget. Retrieved on February 28, 2008 from

<http://publications.budget.state.ny.us/eBudget0809/fyo809littlebook/HealthCareMedicaid.html>