

Seizing A Moment in History:
5 Breakthrough Reforms for American Healthcare

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Executive Overview

We write for no other purpose than to put forward ideas that the two of us have discussed privately for many years. We are non-partisan, non-ideological, and beholden to no sector of the world of healthcare. We do not purport in this paper to solve every problem and/or address every need in the healthcare system. We do hope that our writing will further the public debate and will spur innovation and creative thought.

Our arguments in this paper are divided into various sections (*Table of Contents*). Specifically, we argue that healthcare reformers must adopt well-articulated, well-communicated principles to guide their reform efforts (*Six Principles of Reform*). They must also take the cacophony of voices describing the “problems” in healthcare, and define specifically what the reformers intend to work on (*Three Critical Challenges*). More importantly, reformers must familiarize themselves with and address the subterranean currents that can suck their efforts down into the vortex of failure (*Healthcare’s Five Unspoken Battles*). Only then can they deliver meaningful reforms that will not only be effective (*Five Breakthrough Reforms*), but will also be able to survive the political debate and tension that awaits any proposed changes in the nation’s healthcare system (*The Necessary Politics of Passing Reform*).

For the purposes of this Executive Summary we put aside the details of these many arguments (with hope that the reader will continue to read past the Summary alone) – and simply provide a synopsis of the *Five Breakthrough Reforms* we are proposing:

Five Breakthrough Reforms

Breakthrough #1: Expand Access in Three Stages

The simplest, and easiest means of expanding access is to mandate insurance coverage (similar to the Massachusetts model), and to do so at the individual level. Although some argue against such a mandate, others argue that a mandate alone may be sufficient to improve access. We believe that neither extreme is true, and thus we recommend a three-staged approach to mandated coverage:

Stage 1: Expand the Federal Insurance Pool

With *Medicare* coverage for the elderly, private insurance for the gainfully employed, and *Medicaid* for the very poor, the greatest concern for access focuses on individuals who are self-employed and/or who do not have access to employer-sponsored coverage. The first stage of expanding access, therefore, should be to open the Federal Employee Insurance Pool to individuals, thus creating a national “community rating” for individual buyers of insurance, and giving those individuals access to the purchasing power of several million enrollees. This reform, however, will create an incentive for many employers to

stop providing insurance benefits, and the Federal Pool will still be too expensive for many. Therefore, this reform alone is not sufficient.

Stage 2: Create a “MediHealth” Program for the Working Poor

For the “working poor” (too prosperous for *Medicaid* coverage, too financially strapped to buy into the Federal Insurance Pool, and without employer-paid coverage) we would recommend creating a *Medicare* look-alike product allowing low-income individuals to purchase Medicare coverage. Traditional Medicare provides access to necessary care, and is relatively low in cost. However, Medicare (without supplemental coverage) is not a robust insurance product and is relatively unattractive to consumers. If supplemental policies were **not available** for the “*MediHealth*” *Buy-In Option*, it is unlikely that individuals would choose to stay on Medicare indefinitely. This reform will begin to close the access gap, therefore, for those who are not Medicaid-eligible, but who cannot afford to participate in the Federal Employee pool. Furthermore, the Federal government can easily subsidize the premiums required for this coverage, in order to create greater affordability.

Stage 3: Enact a Federal Insurance Mandate

Once the previous two stages have been enacted – thus creating new options for coverage, the Federal Government should implement a *Healthcare Insurance Mandate*. Although no one likes mandates from the government, such a provision is the only practical way to broaden coverage without totally rebuilding the entire healthcare system. Furthermore, it must never be forgotten that even though most Americans believe healthcare reform is necessary, that same majority of Americans are generally happy with their own healthcare coverage. (It is no different than Americans hating Congress and loving their Congressperson.) Therefore, most Americans would not oppose a mandate, as long as it would leave their healthcare coverage intact. Although several provisions must be passed and various questions must be answered to make a mandate workable, this is the only way to expand access without creating a political upheaval so massive that healthcare reform would be dead on arrival.

Breakthrough #2: Introduce a Bundled DRG¹ by Merging Medicare Part A & B.

The economic divide between doctors and hospitals – created by the historic division of Medicare Part A & Part B – permanently derails most efforts to improve cost, quality, and access. Improving the nation’s healthcare system, while simultaneously lowering cost, means that providers must be brought together under aligned incentives. The answer is to merge Medicare Part A and B by creating a new bundled form of payment.

¹ DRG – “Diagnostic Related Group”, the reimbursement mechanism used by Medicare to reimburse providers for healthcare services.

Eliminating the traditional barriers between Medicare Part A & Part B will allow providers could to develop innovation in care delivery to make care less invasive, less hospital dependent, less physician dependent, safer, cheaper, and more effective. Although *access* to care can be purchased with massive infusions of money, no real improvements in cost control and quality can be achieved unless hospitals and physicians are working together.

Breakthrough #3: Introduce a Chronic Care DRG Based on Time, Not Episodes

A small number of chronic conditions drive the majority of our healthcare costs in this country. Unfortunately, there is no payment mechanism that encourages providers to provide healthcare that keeps these patients healthy; instead, current mechanisms reward providers only when chronic patients suffer episodes of extreme decline or crisis. Similar to Reform #2, this concept would create a bundled payment mechanism for covering all costs of care for chronically ill patients. For example, one lump sum payment would be made (probably on an annual or bi-annual basis) for a diabetic patient that would then entitle that patient to all necessary supplies, check-ups, tests, etc. required to manage the chronic condition. The lump sum payment would also cover any episodic acute care costs that are incurred because of ineffective management of the condition – thus creating an incentive for providers to proactively manage chronic care conditions in order to avoid patient deterioration and higher costs.

Breakthrough #4: Issue New Provider Numbers to Qualified Integrated Entities

Creating bundled payments requires that there is an entity to take the payment and provide the care. We recommend that the government allow existing provider numbers to expire, and then issue new provider numbers for these integrated entities. However, in order to obtain such a provider number the entity would need to demonstrate a minimum of two separate, but equally critical, capabilities:

- *Clinical Capability*: that the organization can provide the entire continuum of care to a reasonable number of people living in a local area.
- *Financial Sustainability*: the organization has the financial wherewithal to sustain itself, and it has all of the necessary elements of a corporate structure (access to capital, board oversight, strategic vision).

We do not recommend that there be mandates as to who these organizations must be sponsored by: we would support physician groups that contract with hospitals, physician groups owning hospitals, third parties contracting with physicians and hospitals, hospitals owning or contracting with physicians and so on. These new organizations should not be judged by their name, or their specific arrangements – rather they should be judged as to how they function – specifically as to how they deliver care based on quality, cost, and service.

Breakthrough #5: Convert Stark Laws to Quality Oversight Requirements.

Currently the “Stark Laws” are an indirect attempt to stop inappropriate healthcare churning. Hospitals and doctors violate the laws when there is a financial incentive paid to the doctor from the hospital for a referral of business. These laws are imprecise and run counter to the necessity of getting doctors and hospitals to work together. With the creation of “longitudinal DRGs” and the physician/hospital entities that can take on those DRGs we will have mitigated the problem that the Stark laws sought to address. We can then pursue the real goal of the Stark Laws: guaranteeing that the best care is recommended and delivered to a patient. Today there is no federal oversight on quality. Stark Laws should therefore be converted to requirements that the new integrated entities provide quality data to their patients – number of procedures done by all hospitals in a geographic area, survival rates, complication rates, etc. This will shift the focus of patient choice of provider to true quality.

Our goal is to leverage this moment to deliver reforms that are politically feasible, and largely work within our existing system – yet create the opportunity for massive improvements to the nation’s healthcare.

Seizing a Moment in History

*Leveraging a rare convergence of factors to reform
American healthcare for the better and for good*

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Why We Write

The work facing the new President and the entering Secretary of Health and Human Services is vast, well known, and critical to raising the standard of healthcare for the nation. Volumes have been written about the problems afflicting America's healthcare system, and every player in the industry has lobbied for reform that will most benefit their own position. Every American has thoughts about what the problems in healthcare are – and ideas for solutions.

We come to this work as individuals who have spent the last two decades working in healthcare – but with a slightly different viewpoint. Across those decades we have worked across the entire healthcare continuum– hospitals, health systems, physician groups, nursing organizations, insurance companies, medical device manufacturers, and pharmaceutical firms. In addition we have worked on healthcare problems in a dozen countries, and for organizations as wide ranging as the Aga Khan Health System to the British National Health Service, from little Tompkins Community Hospital in Ithaca, New York to Kaiser Health Networks, from Merck Pharmaceuticals to United HealthCare.

We write for no other purpose than that we feel that at this moment – when real and significant change might be possible – we have a duty to put forward ideas that we have discussed privately for many years. We are non-partisan, non-ideological, and beholden to no sector of the world of healthcare.

We believe there are three challenges that the new Administration must face:

1. **Articulate a clearly defined problem set.** The Administration must openly, and concisely define the problems that it intends to solve. The problems in healthcare are myriad: poor incentives, bad quality, lack of access, inadequate government payments, onerous unfunded mandates, unreadable bills, a reliance on paper – and on and on. First, the Administration must define what problems it intends to solve, and communicate that problem set to the American people.
2. **Embrace a concise list of reforms.** We seek a short list of reforms that will have the maximum impact on the largest number of problems. Reforms can be bold – but it is better if they are few in number, and deliver the greatest benefit.
3. **Guarantee political feasibility of proposed reforms.** Sweeping legislation that fails to pass may worsen our plight. The country does not need to wait another 15 years for healthcare reform. Reforms should leverage existing demonstration projects, pending legislation, and political leverage.

We do not purport in this paper to solve every problem and/or address every need in the healthcare system. By its very definition healthcare will always be a clash between the public good and individual need, between the provision of charity and the rigor of business, between the marvels of technology and the frailty of the human condition, and even between the widespread needs of a mostly healthy population and the profound special needs of the sickest amongst us. There will always be tension and imperfect answers.

That said, we believe significant improvement is possible on many fronts. Here are our thoughts.

The Six Principles of Reform

Change alone is not enough; we want to engage in constructive change. While we cannot wholly prevent unexpected consequences, we must begin with a set of fundamental principles that should be understood by every party. While many have critiqued the nation's health system – we must all recognize that much that it has achieved is a miraculous good – just not an unalloyed good. Here we recognize that in effecting change, we should not kill the goose that lays the golden eggs.

- 1) **Reform must preserve the core tenants of the American healthcare system that are truly the envy of other countries** – rewarding hard work, rewarding innovation, rewarding high levels of personalized service and fast access. Britain, Australia, and a myriad of other countries are currently attempting to mirror this part of the U.S. health system. The “profit” incentive has led us to be the source of 80% of healthcare innovation in the world. In every area – medical devices, biotech, pharmaceuticals, and innovative procedures – we are a net exporter and this incentive is essential to our success.
- 2) **Reform must equally address all three of the core faults in the current system – Cost, Access, and Quality.** Unfortunately, most discussions of reform fail to address all three simultaneously. The political debate is most often focused on **access** – getting more people insured. The discussion for employers and insurers centers on **cost** -- maintaining competitiveness. Consumers and providers are both concerned about the twin issues of **cost and access** – consumers wanting to keep coverage they can afford, and providers wanting to be reimbursed for all the care they provide. Although it is paid lip service, **quality** often falls victim to both the (wrong) assumption that it can be taken for granted and the non-stop (parochial) debate amongst stakeholders as to what the true definition of “**quality**” should be. Cost, Access, and Quality are currently insufficient, and all three must be dramatically improved by any reform measures that are enacted.
- 3) **Reform must simplify, not complicate, the current healthcare continuum.** It is a well-known principle in other industries, that complexity is the enemy of both efficiency and quality. Complexity increases the likelihood of error, creates unnecessary burdens for management and oversight, and diminishes the prospect of innovation and improvement. In healthcare, all facets of care are currently too complex, and any effort to simplify the system is likely to translate into both better quality outcomes and improved cost structures.
- 4) **Reform must guarantee effective, efficient, and transparent oversight of the system in order to both guard against abuses and to encourage constant improvement.** To date, the focus of oversight has been just on *controls* –

stopping the most egregious behaviors and the most intolerable of unethical actions. This, however, creates a “floor” for poorest performance, but does nothing to elevate performance to ever better outcomes. Therefore, in addition to appropriate *controls*, the importance of *incentives* must be fully grasped and leveraged in such a way as to propel healthcare performance to ever-higher levels of excellence.

- 5) **Although reform must be bold, it must be politically possible.** It does no good to pontificate on the idyllic and perfect scenarios of which many pundits dream, if in fact the political will, the public support, and/or the practical ability do not exist to make those scenarios a reality.

- 6) **Reform should leverage existing laws and regulations as much as possible in order to reduce complexity, minimize resistance to change, and speed the timetable for implementation.** Changes “at the margin” – if highly effective – will require less analysis, will shorten the time that the public and providers require to adjust to any changes, and will thus minimize the overall costs of reform – a critical benefit in this time of extreme fiscal crisis.

Defining the Problem Set: The Three Critical Challenges

The nation's "health system" is neither. It is focused on sickness, not on health, and it operates as a diaspora of providers, not as a well-oiled machine. Despite valiant attempts to improve care across the last few decades, we have seen instead a disintegration of the system as doctors, hospitals and insurance companies have increasingly worked at cross-purposes. This is the result of a strangling set of conflicting incentives, largely developed by the federal government. While each segment is responding rationally to the incentives in their sector, those incentives are directed to "problems" (disease or injury) rather than "health" (the longitudinal well being of the patient). There is no incentive to focus on the patient, nor for the players in healthcare delivery – hospitals, primary care doctors, specialist doctors, and insurers - to work as a team.

Insurance companies have abandoned controlling medical costs, and have instead simply focused on contracting battles over unit pricing. Physicians seek the highest price per unit possible, and then do as many units as possible, avoiding complicated cases and patients (they are paid by unit, not by time). Hospitals focus on maximizing their geographic scale in order to demand higher prices from insurers, and then follow the incentive structure to fill their beds, rather than work to find ways to keep patients out of the hospital. The average Medicare beneficiary with chronic disease has 12 doctors that don't talk to each other and 15 medications (many of which are contraindicated), and as a result of a lack of care management ends up in crisis, is sent to the ER, and is admitted as an inpatient. This is the least cost effective, and most inappropriate course of care.

After decades of patchwork solutions for the nation's healthcare system, three critical challenges remain:

- **Lack of Access**

- *Lack of Insurance* -- We have more than 45 million Americans with no insurance and who, therefore, are limited to emergency-only healthcare. For these Americans, primary care is delayed or denied, while tertiary healthcare results in bad debt for providers and/or bankruptcy for individuals. An analysis of hospital closures in the last decade shows highest rates of failure in areas with the lowest levels of commercial insurance. Hospitals lose money on Medicare and Medicaid, and when the ratio of indigent patients to commercially insured patients gets too far out of balance, failure is inevitable. We have a system that leads to bad care for patients, personal bankruptcy for citizens, and the failure of critical non-profit providers in our communities.
- *Under Insurance* -- Increases in the "under-insured" are significant. The

median deductible for an insured person in the US was \$500 from 2001 through 2007. In 2008 that number doubled to \$1000. This exacerbates the access problem, as people are unwilling to spend and wait to get sicker before getting treatment rather than focusing on prevention and primary care. In the event of a serious medical event, they are unable to pay, and do not have the savings to cover the expense.

- **Significant Quality Challenge**

- *Wide Quality Variability* -- It is well documented that social status, insurance status, race, and geography are more important in determining the speed and level of care received than medical need. In addition, physicians cling to the idea that medicine is an “art not a science.” They use this argument to argue against protocols, evidenced based medicine, and any measurement of their work.
- *High Rates of Error* -- Medical error continues to ravage patients with avoidable deaths and impairment continuing at unacceptable and alarming rates. While Medicare is making strides here (no longer paying hospitals for conditions created during the hospital stay) much more needs to be done.
- *Acceptance of Inappropriate Care* -- Healthcare providers are extremely slow to adopt new and proven therapies, especially if they are less invasive and less profitable. Large percentages of providers continue to use disproven therapies for years after they are discredited. This is partially a result of our current payment system: there is no incentive for providers to be early adopters: early adoption often means spending more time with the patient, and thus doing fewer units and a lower income.
- *Inequitable Investment Driven by Unequal Profit* -- Healthcare investments in local infrastructure are driven by market profitability, not by patient need. Profitable services, such as cardiac care, sports medicine, and orthopedic care continue to receive a disproportionate share of new investment: advanced technology, hospital bed space, clinical training. Less profitable, yet important, services – primary care, geriatric care, and disease management – are routinely underfunded.

- **Excessive Cost**

- We spend 16% of our GDP on healthcare – far more than other industrialized countries – without commensurate benefits in public health, survival rates, etc. Key to this problem: while government and commercial payers are interested in total costs, they have attempted to control total expenses by restricting *unit pricing (DRGs)*. Providers, therefore, in an

attempt to bolster profits are only incented to control their unit costs, while simultaneously increasing the volume of units delivered (patients, procedures, and interventions). Time and again, therefore, government efforts to control **total** costs have failed because providers work to increase volumes commensurate with any restrictions in price.

We would articulate the problem to the public as follows:

- 1) **Lack of Access** due to the high cost of insurance, and the structure of insurance in the US.
- 2) **Poor Quality** as a result of poor incentives to providers, lack of federal oversight, and a divorcing of costs from the consumer.
- 3) **High Costs** due to poor incentives, wrong insurance structure, and poor coordination between providers.

The goal of the administration must be to simultaneously get more people access to insurance, improve the quality of care, and lower the cost of care, not just for consumers, but also for the nation as a whole.

Healthcare's "Five Unspoken Battles"

While they are reluctant to discuss it (and are often in fact unaware of it), our national healthcare stakeholders are too often at war with themselves, rather than at war with the true enemies of disease, ignorance (both of the public and of providers), and healthcare complexity. Much of this war is the result of a fight over the healthcare dollar, and it diminishes our national ability to create consensus and to improve performance. We see five key battlefronts in this war:

- *Battlefront #1: Primary Care Doctors Against Specialists*
 - Primary care physicians make about \$130,000 per year. Specialists make from \$250,000 to over \$1 million. During the early 1990s, primary care doctors were told that they would control the healthcare dollar (as gatekeepers) and that their salaries would rise. As the HMO model stalled, and capitation did not gain traction, primary care docs were left in the cold. Across the next decade, specialists took the lead, joint venturing on hospitals, building their own ambulatory care centers, and increasing their income. While best care would result from these doctors working together – there is now little love lost between them. In addition, many medical school graduates are carrying upwards of \$200,000 in school loans. Increasingly they are choosing to go into the specialty professions, and we are seeing a shortage of primary care physicians – internists, geriatric physicians, etc.

- *Battlefront #2: Doctors Against Hospitals*
 - 20 years ago the hospital was the center of the physician community. All doctors – both specialists and primaries – admitted patients, and all rounded in the hospital. As payment for rounding dropped, procedures moved outpatient, and primary care physicians had fewer patients in the hospital, hospitals adopted the hospitalist physician model. This makes for better and more efficient care, but now few primary doctors have any interaction with the hospital. They practice in small offices (mostly in groups of 3-5) and there is little ability to influence their quality or efficiency of their care.

 - At the same time, specialists began to develop means to take the “technical” revenue from the hospital. Not content to be paid for their work on the patient, specialists sought ways to capture more of the money that was being paid to the hospital. Specialists demanded joint venture arrangements, and often started competitor facilities when the hospitals did not comply.

- While there are wonderful examples of doctors and hospital working well together (Sutter in Sacramento CA, Mayo Clinic in Rochester MN, Trinity Mother Frances in Tyler TX, etc) the norm is one of “cold war.”
- *Battlefront #3: Insurers Against Providers*
 - Health insurance companies divide their revenue into three buckets: medical costs, administrative costs, and profits (or in the case of the tax exempts – margin). The typical insurer has 80-85 percent medical costs, 10-20 percent administrative costs, and 1-10% margin. The dirty secret in the insurance industry is that they no longer focus on controlling the largest cost – medical. Despite their recognition of the 80/20 rule, they cannot effectively sell restrictive, gatekeeper HMO products – and thus, they have yet to find ways to effectively control costs. In addition – all insurers take their cue from Medicare – and so our whole system is based on negotiations over “unit price” (DRGs).
 - What little “medical cost” control health insurance companies attempt is done through aggressive contract negotiations with providers. Here, both sides have spent the last decade scaling up so that they bring larger “armies” to the battle. Health Systems have consolidated and merged in order to create large regional presence; insurers have worked hard to build “critical mass” dominance and market share in select areas. This creates an ongoing “clash of the Titans” with each side threatening to “go nuclear” -- the insurer cannot live without the large provider network that is controlled by the regional health system, and the regional health system cannot live without the dominant insurer in their market. In essence, both sides make peace only by exploiting their virtual oligopolies at the expense of patients and employers. Providers once again focus on getting the highest unit price possible, and then churning as many units as possible. The insurer focuses on total cost per member – but does little to incent a decrease in that cost. Employers and patients end up paying much more for their healthcare coverage.
- *Battlefront #4: Patients Against Payers*
 - The economic distortions of the healthcare market place are well known. In a typical “free market”, consumers actively seek to find the highest quality goods and services for the lowest possible price, and this constant struggle between producers and consumers results in ever-improving efficiency, higher quality, and increased trade. But, “free markets” are based on three critical factors that will be forever missing in healthcare.

- 1) The first is “perfect information” – consumers having an effective method of determining true value and actual quality. Even with increased reporting of “quality metrics” (CMS measures, magazine rankings, consumer group ratings, etc.) healthcare consumers / patients do not have access to even good information, much less perfect perspective. Because of gaps in expertise, the opacity of the system, and the complexity of multiple providers, consumers find themselves caught in the cross fire of the previous 3 battlefronts -- each group trying to ally the patient / consumer to their point of view, and no one providing truly robust and accurate information that the patient can trust.
 - 2) The second is the ability to “walk away from the transaction”. If you don’t like the price or value that is offered by a car dealer, you can choose not to buy. Patients are not free to walk away from the purchase of care, and are, therefore, captive to the system.
 - 3) The third is a direct economic exchange between producer and consumer. In healthcare, the consumer must deal simultaneously with both the healthcare provider who delivers service and the payer who actually pays for the service to be delivered.
- The result of these distortions is twofold...
- 1) Healthcare *consumers* are unable to make informed decisions as to the quality and value of the healthcare they consume, resulting in a “more is better” approach to healthcare consumption. In fact, *consumers* are almost militant in their resistance to working with their insurers. They are slow to make their co-pays unless pressed to do so by providers. They constantly choose to purchase lower priced health plans that do *not* meet their expectations or needs, even if they could afford appropriate care. They punish health plans that lower costs through exclusive provider contracts (limited networks). If they are healthy (and self-employed), they often make a conscious choice to avoid the hassle of insurance altogether, choosing to go without insurance by relying on the (insufficient) network of emergency care services that can be accessed if absolutely necessary.
 - 2) *Payers* are plagued with a customer base that constantly drives up utilization and actively resents any effort to control costs even though it is the role of the payer in our healthcare system to do so.

As a result, payers provide products that the typical consumer can neither understand nor navigate. They create products with exclusions and exceptions that a “reasonable consumer” would commonly expect to be included. They generate complex *Explanation of Benefit (EOB)* documents that confuse rather than enlighten. Even if concerned about quality, they tend to “deny” benefits rather than “channel” patients towards better alternatives. They place a premium on costs, but place only limited importance on enhanced service quality and/or improved medical outcomes. They tend to treat the patient / consumer as an adversary to their work, rather than as a potential partner who could help to improve the value gained from the healthcare system.

- *Battlefront #5: Government Funding Against Commercial Insurance*
 - Perhaps the most difficult of the battlefronts for the government to admit: the high cost of commercial insurance is a direct result of the federal government underfunding Medicare and Medicaid. The government simply does not pay its fair share for the programs it sponsors.
 - The current level of underfunding to hospitals and physicians is over \$88 billion a year. The regulations for Medicare and Medicaid change constantly and there are many unfunded mandates that are required for program participants. An example would be the current Medicare rate per unit of service for anesthesia is \$11 while the market rate paid by hospitals is \$88. The balance is typically made up by hospitals subsidizing the anesthesia groups for the difference. The hospital, in turn, charges more to commercial insurers to try and compensate for the shortfall.
 - As a result, when the government implements funding changes designed to reduce spending, the government is essentially banking on the ability of hospitals and other providers to remain financially solvent by shifting costs to commercial payers. This silent shift of government responsibility creates additional tension and conflict within the health system. It also exacerbates the other battlefronts as providers desperately scramble to steal revenues from other stakeholders in order to compensate for government shortfalls.

While these five battles wage on – one is left with the question: Who is ultimately accountable for elevating quality, lowering cost, and increasing accessibility to healthcare? The answer is: no one.

Therefore, any successful reform must eliminate the conflicting incentives that have led to the “*Five Battlefronts*” mentioned above. We must shift the incentives of the current system away from rewarding unnecessary production (*the number of units*) and inflated cost (*the unit price*) towards a system that rewards treating the patient longitudinally.

The best models of care we have in this country are non profit (Foundation) based multi specialty medical groups – Group Health, Cleveland Clinic, Mayo Clinic, Geisinger Clinic, Kaiser or academic medical center faculties. These are organizations that have worked to reduce (even eliminate) the tensions of the Five Battlefronts – despite the fact that they must work within the constraints of a poorly aligned system.

Our suggestions will create a natural environment where consumers can consider quality and cost as they choose insurance and care, providers will be paid to care for the health of the consumer - not for individual activities, quality will be improved as patient care is more effectively managed across the healthcare continuum, and costs will fall as the incentives work more effectively.

The Five Breakthrough Reforms

There are five *Breakthrough Reforms* that can satisfy the fundamental principles of reform explained earlier and that, in combination, can defuse the battlefronts:

1. Expand Access in Three Stages
2. Introduce a Bundled DRG by Merging Medicare Part A & Part B
3. Develop a Chronic Care DRG Payment
4. Issue New Provider Numbers to Qualified Integrated Entities
5. Convert Stark Laws to Quality Oversight Requirements

Breakthrough #1: Expand Access in Three Stages

What is often called an “access” problem in healthcare is really a “payment” problem. Insurance in the US is actually a two-pronged financial instrument to pay for healthcare. First it is means of paying for care that the individual knows he or she wants: delivery of a baby, regular check-ups, perhaps prescriptions for a pre-existing condition. Second it is “Catastrophic coverage” to pay for the unknown and the unaffordable. The inclusion of “desired benefits” within the insurance system dramatically distorts the financial workings of the entire healthcare system. Unlike other insurance products which consumers do not want to use – fire insurance, homeowners insurance, and car insurance – consumers are incented to access their healthcare insurance on a regular and robust basis.

Having insurance tied to employment exacerbates this cycle of “desirable consumption”. Since consumer are divorced from price, and healthcare insurance is part of their compensation package, they rationally seek to maximize the value of this employment benefit. Thus, consumers seek to use the most expensive healthcare services, and consumers expect that every healthcare service should be covered.

The obvious result of these payment distortions is very expensive insurance, and very expensive healthcare.

The problem of access – or more correctly, payment reform -- is thus twofold: first, lowering the cost of care so that coverage is more affordable, and second, expanding federal coverage for more of the nations low wage earners.

If the goal is “universal coverage” – and most agree that it should be – then there are only three avenues to reach that goal: a *government system* (which would be simple, but lack any of the advantages of market forces), a *purely commercial system* (which is not known in nature), and a *hybrid* (which is what we have, but with a giant gap with 43 million people in it). In expanding coverage we will need to expand both the government side of the equation – perhaps helping individuals who are not quite at poverty, but who still cannot afford a commercial premium, and the commercial side.

The simplest, and easiest means of expanding access is to mandate insurance coverage (similar to the Massachusetts model), and to do so at the individual level.² Although

² In addition to expanding access to insurance, the structure of insurance must eventually be addressed. We must seek to eliminate the two prong nature of health insurance: group purchasing for “known” desired services (delivering a baby) versus catastrophic coverage (injuries from an accident, cancer). In the past the firms offered “major medical” separate from hospitalization and we may need to revisit that idea. Another way to think of this is as developing a universal “catastrophic coverage” program. Following that, firms could then sell people packages of amenities for what they choose to consume. We believe that this

some argue against such a mandate, others argue that a mandate alone may be sufficient to improving access. We believe that neither extreme is true, and thus we recommend a three-staged approach to mandated coverage.

Stage 1: Expand the Federal Insurance Pool

With *Medicare* coverage for the elderly, private insurance for the gainfully employed, and *Medicaid* for the very poor, the greatest concern for access focuses on individuals who are self-employed and/or who do not have access to affordable employer-sponsored coverage. The first stage of expanding access, therefore should be to open the Federal Employee Insurance Pool to individuals, thus creating a national “community rating” for buyers of this insurance, and giving those individuals access to the purchasing power of several million enrollees. This idea was discussed widely during the recent presidential campaign, and it is worth enacting.

However, if we continue to tie health insurance to employment, this move is likely to have two adverse consequences. Employers will weigh the cost/benefit of dropping coverage and facing the tax penalty. For many, the difficulties of providing coverage will outweigh the cost of the penalty. The employees of these firms will be left to purchase coverage on their own. This coverage (even with access to the Federal Employee insurance pool) may still be more expensive than they are willing to pay. They may then be moved from having had insurance through work, to now not having any insurance at all. Therefore, this reform alone is not sufficient.

Stage 2: Create a “MediHealth” Program for the Working Poor

For the “working poor” (too prosperous for *Medicaid* coverage, too financially strapped to buy into the Federal Insurance Pool, and without employer-paid coverage) we would recommend creating an additional option to close the gap between *Medicaid* coverage and more traditional insurance (the *Federal Insurance Pool Buy-In*).

Specifically, we would recommend creating a *Medicare* look-alike product; allowing low-income individuals to purchase *Medicare* coverage. Traditional *Medicare* is not a particularly deluxe healthcare insurance product – thus, millions of *Medicare* recipients purchase *Medicare Supplement* policies to close the gap for their routine healthcare needs. That said, bare bones *Medicare* coverage is sufficient to provide necessary care, and it is relatively low in cost.

requires further study – as does personal financial responsibility. If we have a “mandated” program then we need to consider whether or not healthcare expenditures for family members (including parents *MediGap* coverage) should be 100% deductible with no threshold.

By using the Medicare structure to provide this coverage, the government could avoid expensive bureaucracy costs. At the same time, if supplemental policies were **not available** for this *Medicare Buy In Option*, it is unlikely that individuals would choose to stay on Medicare indefinitely. This reform will begin to close the access gap for those who are not *Medicaid*-eligible, but who cannot afford to participate in the Federal Employee pool – especially if the government chooses to subsidize premiums at a graduated rate to guarantee affordability. At the same time, this stopgap approach is unlikely to create a totally government-funded system for long-term healthcare coverage that the government could not afford to maintain.

Stage 3: Enact a Federal Insurance Mandate

Once the previous two stages have been enacted – thus creating new options for coverage, the Federal Government should implement a *Healthcare Insurance Mandate*. Although no one likes mandates from the government, such a provision is the only practical way to broaden coverage without totally rebuilding the entire healthcare system. Furthermore, it must never be forgotten that even though most Americans believe healthcare reform is necessary, that same majority of Americans are generally happy with their own healthcare coverage. (It is no different than Americans hating Congress and loving their Congressperson.) Therefore, most Americans would not oppose a mandate, as long as it would leave their healthcare coverage intact.

Although several provisions must be passed and various questions must be answered to make a mandate workable, this is the only way to expand access without creating a political upheaval so massive that healthcare reform would be dead on arrival. Following are some specific suggestions for making this mandate workable, acceptable, and effective...

- In order to simplify claims processing and to enhance consumer understanding of insurance products (and the later billings for care), the number of market offerings should be modified and reduced so that all insurers could offer the consumer a choice of a set number of products. This simplifies the purchasing process, enhances portability, and eliminates consumer confusion and forces insurance companies to compete on other issues like quality and service
- Claim forms and billing submission processes should be standardized to one accepted set of forms and processes. The data required for complete bill should be uniform between all carriers and the Federal and State programs.
- The prohibition against gene testing by insurance companies should be incorporated under the HIPAA laws in order to protect consumers, prevent

cherry picking by insurance companies, and improve access to all individuals regardless of their genetic makeup.

- Insurance plans should be required to means test clients prior to a sale to ensure that individuals purchasing insurance actually qualify financially and have the financial reserves required to support an insurance product that has high deductibles and co-pays. The required deductible could be placed into an interest-bearing medical savings account that was locked to the product so that the monies would transfer automatically and immediately at time of service to cover deductibles and co-pays. This approach would eliminate bad debt for providers and preserve the individual's family assets and financial status in the event of a catastrophic illness. This would add efficiency to the collection process, eliminates suits and bankruptcies due to illness.
- Community rating" should be done across broad geographic areas – or even nationally. This will better spread the risk and reduce cherry picking by third-party insurers.
- The process of adjusting rates should be based on quality outcomes and improvement of health status versus current method of inflation and geographic area.
- Insurance should be made available to all individuals and the concept of pre-existing conditions should be eliminated in order to preserve the original concept of insurance. Individuals with pre-existing conditions and the uninsured could be pooled and distributed on a random basis according to the percentage market share held by the individual third-party insurers. If the laws were changed for ERISA, then all businesses would also share equally in the expense of covering these individuals.

Breakthrough #2: Introduce a Bundled DRG by Merging Medicare Part A & B

This single idea will address both cost and quality, and will also reduce the friction caused by healthcare's "unspoken battles" that we discussed above. No single idea would more improve care and lower acute care costs in this country with less disruption to the healthcare system writ large.

The splitting of the Medicare system into two components is a vestige of political debates from the 1960's. The American Hospital Association sided with the Democrats to create a universal, tax-supported system in Medicare Part A. The American Medical Association teamed with the Republicans to create an insurance premium supported system in Medicare Part B.

Because of this economic divide, a significant amount of effort is wasted when hospitals try to beg, encourage, shame, or nudge physicians towards higher care quality standards, or more efficient care.

Likewise, physicians are incented to do more procedures without any oversight or restrictions, because hospitals end up suffering the costs (labor expenses, device costs, etc.) of the decisions that physicians make. The economic division keeps the two parties necessary for improving cost, quality, and access at odds. They must be brought together under aligned incentives. We should merge A and B – and create a new bundled form of payment. This will require new "qualified integrated entities" to receive the payment and deliver care, which we discuss in Breakthrough #4.

- At the core of this merger would be the consolidation of prospective payments for both hospital and physician care into one consolidated "DRG". That consolidated payment would be for **all** services required by a specific diagnosis.
- Hospitals would contract with, hire, or partner with physicians in order to receive a consolidated DRG. (This would not be left to hospitals alone – see Breakthrough #4). Safeguards could easily be attached that would guarantee coverage in smaller markets, eliminate unfair competitive practices, and so on. This will give added strength to hospitals to push quality standards during the delivery of care.
- Integrated entities could be held accountable for additional quality metrics and for additional quality improvement because they would now truly control the continuum that is being measured and improved.

- With the traditional barriers between Medicare Part A & Part B coverage eliminated, providers could innovate care to be less invasive, less hospital dependent, less physician dependent, more effective, more flexible, and less costly. For example, as long as quality guarantees were in place, providers might choose to provide some care using nurses or trained technicians who could actually spend more time and would be more specialized to provide certain care, rather than more expensive and often scarce physicians. Likewise, barriers to moving care from expensive in-patient venues to less costly office-based or home-based settings would be removed.
- Although somewhat counterintuitive and contrary to current policy, the government could adjust DRG reimbursements to actually favor less invasive, office based, or earlier interventions. Officially, current policy is for reimbursements to reflect the actual costs of care – supposedly creating no profit incentive to favor one type of treatment or one type of patient over another. Historically, this has not been the reality with interventional DRGs -- cardiac interventions, orthopedic interventions, hospital based care, etc. – being more profitable than other care categories. By shifting profitability – actually paying for costs plus reasonable profit margins -- to overall lower cost, yet equally effective, types of care, hospitals (and doctors) would be incented to use those lower cost alternatives. Whereas cost shifting has been attempted in the past, it has always meant that either hospitals win and doctors lose or vice versa. With a consolidated DRG, the parties would be aligned to provide lower cost, yet higher profit, services.³

³ This reform would allow HHS to leverage an idea that the beltway has already embraced -- the Medical Home Demonstration Project. Created by Congress as part of the Tax Relief and Health Care Act of 2006 this project was recently expanded from a 10 Million dollar program, to a 100 million dollar program. The project will be conducted in eight states and will involve about 400 practices, 2,000 physicians and 400,000 Medicare beneficiaries. Physician practices must qualify for one of two medical home tiers. To qualify as a Tier 1 medical home, a practice would have to meet 17 basic medical home capabilities, including use of a health assessment plan, use of integrated care plans, tracking of patient tests and provider follow-up, and providing medication reviews. Tier 2 medical homes would have to meet the 17 basic capabilities, as well as additional criteria, including the use of electronic health records.

Breakthrough #3: Introduce a Chronic Care DRG Based on Time, Not Episodes

Similar to Reform #2, this concept would create a bundled payment mechanism for covering all costs of care for chronically ill patients: diabetics, COPD patients, CHF patients, and so on. For example, one lump sum payment would be made (probably on an annual or bi-annual basis) for a diabetic patient that would then entitle that patient to all necessary supplies, check-ups, tests, etc. required to manage the chronic condition. The lump sum payment would also cover any episodic acute care costs that are incurred because of ineffective management of the condition, thus creating an incentive for providers to proactively manage chronic care conditions in order to avoid patient deterioration and higher costs.

Unfortunately, most reform proposals lump chronic care management into the “primary care bucket”. This is a fundamental error because primary care for a healthy population is, by nature, episodic (except perhaps for routine well-care physical exams or screenings). Chronic care, on the other hand, requires constant and active management and intervention. Furthermore, the cost advantages of good primary care are always long term, while the cost advantages of high quality chronic care management can be immediate. (Getting a 25 year old to stop smoking costs money today and saves money years down the road; therefore insurance companies are hard pressed to make an investment in smoking reduction programs. Conversely, daily weight and fluid management for a CHF patient today will directly eliminate unnecessary hospitalizations and costly interventions within the same year). Therefore, chronic care and primary care should be managed as different types of care delivery, deserving different payment mechanisms.

The only widespread innovations in chronic care delivery were introduced by and died with the rapid spreading and then equally rapid demise of capitation in the mid 1990’s. Healthcare providers received lump sum payments to care for entire populations and were – for the first time – truly incented to keep chronic care patients healthier (and, therefore, to keep total costs under control). Unfortunately, with total population management, healthcare systems are incented to exclude patients with chronic conditions from their patient base. A Chronic Care Bundled payment would provide a type of capitation for patients with the most common chronic conditions. This would create an incentive system to innovate new methods of care delivery and cost avoidance for these disease-specific populations.⁴

⁴ Pending legislation, **Independence at Home Act** could be used to create a chronic care DRG. While not perfect this act is intended to drive providers to work together to reduce the hospitalizations associated with chronic conditions and create a new quality standard for the treatment of these patients. IHA’s incentive structure (which guarantees a 5% savings for Medicare, and offers the providers 80% of the rest of the savings) would unleash a tidal wave of innovations in disease management.

Breakthrough #4: Issue New Provider Numbers to Qualified Integrated Entities

Creating bundled payments requires an entity to take the payment and provide the care. This entity must be able to provide physician care, outpatient care, diagnostics, and hospital care. Many of these entities already exist (Mayo Clinic, Geisinger Clinic, Group Health Cooperative, Intermountain Health) – but bundled payment will shift our entire system to these types of entities.

We recommend that the government allow existing provider numbers to expire, and then issue new provider numbers for these integrated entities. However, in order to obtain such a provider number the entity would need to demonstrate a minimum of two separate, but equally critical, capabilities (though more could be added)⁵:

- *Clinical Capability*: that the organization can provide the entire continuum of care to a reasonable number of people living in a local area.
- *Financial Sustainability*: the organization has the financial wherewithal to sustain itself, and it has all of the necessary elements of a corporate structure (access to capital, board oversight, strategic vision).

We do not recommend that there be mandates as to who these organizations must be sponsored by: we would support physician groups that contract with hospitals, physician groups owning hospitals, third parties contracting with physicians and hospitals, hospitals owning or contracting with physicians and so on. These new organizations should not be judged by their name, or their specific arrangements – rather they should be judged as to how they function – specifically as to how they deliver care based on quality, cost, and service.

⁵ To better understand the concept of “qualifying” an entity to receive a provider number, we would recommend that the HHS study Britain’s recent introduction of the NHS Foundation Trust. Although a Foundation Trust is not a fully integrated provider system, the government of the UK has created a review process – overseen by an independent agency (Monitor) – that considers financial stability and clinical quality when granting special powers and flexibility to an existing hospital. In exchange for greater latitude than a traditional NHS facility enjoys, a Foundation Trust must also meet various mandates for governance and public involvement.

Breakthrough #5: Convert Stark Laws to Quality Oversight Requirements.

Thus far our four proposals should help to lower the costs of care, increase the affordability of insurance, create universal coverage, and improve quality. There is, however, a necessary and critical final step – creating “transparency” in the pricing and quality of the services delivered, so that consumers can do a better job in “purchasing” healthcare. In the last few years the nation’s healthcare system has made great strides in healthcare quality – but what is missing is a federal authority for quality in healthcare.

Currently the “Stark Laws” are an indirect attempt to stop inappropriate healthcare churning. Hospitals and doctors violate the laws when there is a financial incentive paid to the doctor from the hospital for a referral of business. Unfortunately, these laws are imprecise and run counter to the necessity of getting doctors and hospitals to work together.

With the creation of “longitudinal DRGs” (*Breakthrough Reforms #2 and #3*) and the physician/hospital entities that can take on those DRGs (*Breakthrough Reform #4*) we will have mitigated the problem that the Stark laws sought to address. We can then pursue the real goal of the Stark Laws: guaranteeing that the best care is recommended and delivered to a patient. Stark Laws were implemented when our tools for managing quality were blunt and inadequate. Today’s measurement systems are different in kind.

Stark Laws should therefore be converted to regulations that will require providers to provide quality data to their patients – number of procedures done by all hospitals in a geographic area, survival rates, complication rates, etc. If providers were required to provide basic CMS quality metrics (plus new ones) to their patients, this would begin to shift the focus of provider choice (both doctor and hospital) to quality rather than simply the recommendations of individual providers or the attractiveness of certain health system “brand names” that might not actually guarantee better outcomes.

Again – we are not recommending a slew of unfunded mandates. We are recommending that the federal government create a transparency to quality. Many organizations are providing quality data to the public – but that fact has actually made it even more difficult for the public to understand. We need federal oversight of healthcare quality, just as we have federal oversight of the airline industry, nuclear power generators, automobile safety, etc.

The Practicality of These Suggestions

We believe that these five *Breakthrough Reforms* are credible and worth of careful consideration by the new Administration for the following reasons...

- 1) **Nothing will happen without Physician / Hospital cooperation.** The largest percentage of the healthcare dollar goes to hospitalization. Studies demonstrate that 89% of quality improvements require physician involvement. Likewise, virtually all effective cost reduction strategies impact or are impacted by physicians. No system of care will work to elevate access, improve quality, and decrease costs if these two key components of the healthcare continuum continue to be separately managed.
- 2) **Medicare Works.** Although much maligned by providers as “inadequate”, this system has provided universal coverage for the elderly for decades. At the same time, innovation has been encouraged, most hospitals have remained profitable, and fast entry into the system has been maintained.
- 3) **As goes Medicare, so goes the Health System.** The significant investment that the Centers for Medicare & Medicaid Services (CMS) makes to create equitable payment systems – DRGs, RBRVS⁶, etc. – cannot be replicated and/or improved upon (without massive investments) by private insurance companies. As a result, today’s insurance contracts base payments on Medicare reimbursement: *Medicare Payment +/- a given percentage.*
- 4) **As goes Medicare driven quality, so goes the Health System.** History shows that when CMS requires quality improvements and/or efficiencies are generated to guarantee profitability of a DRG, those benefits transfer across all patients. Doctors and hospitals do not adjust “how” they provide care based on the payment system. (There is evidence that payment systems drive “whether” a patient is prescribed appropriate and necessary care, but once that care is *prescribed* the method by which that care is *delivered* is not unique to payment type.)
- 5) **Expansion of non-physician providers.** There are a significant number of services, even within the acute care setting, that could be managed by a non-

⁶ RBRVS: Resource-Based Relative Value Scale. As hospitals are paid based on the DRG (Diagnosis related grouping) physicians are paid by CPT Code (Current Procedural Terminology). An independent group determines how much physician work, practice expense, and malpractice expense are involved for each CPT – and then a price to be paid is set for the procedure.

physician (routine hospital rounding, discontinuing pharmacological care, anesthesia services, etc.). With a consolidated payment, hospitals would be better able to swap providers (where appropriate) to less costly and better capable specialties. For example, a Clinical Nurse Specialist may be better positioned to manage routine post-surgical care than the surgeon. The CNS would be less expensive and may be better positioned to look for non-surgery related complications, gaps in nursing care, and so on.

- 6) **Cost Controls can be more easily imposed.** With the merger of the DRG, some of the estimated 30% of current expenditures that are wasted should be able to be recaptured by CMS. So, for example if a DRG payment to the hospital is \$3000 and physician reimbursements total \$1000, studies would show that as much as \$1200 of the total is wasted in the American healthcare system. The government should be able to gradually claw back these inefficiencies – reducing, for example, the initial combined DRG to \$3800 or freezing future inflationary increases, etc. Cost controls are never popular and will always be resisted, but, combining cost control with the freedom for providers to cooperate more routinely will allow cost reductions to be done through innovation and the reduction of waste, rather than through the denial of service or the degradation of quality.
- 7) **No New Infrastructure.** Although some hospitals will be challenged by the need to reform their own contracts, build new payment arrangements with doctors, and manage larger and more complex organizations, many hospitals that own their physicians or have strong networks already in place would have far fewer challenges to address. At the same time, large physician groups would now find additional financial benefit in keeping patients out of the hospital, and thus gain some of the technical revenue that they have long sought.
- 8) **Less complexity.** The government would be able to focus on fewer providers – working much more closely with the new “entities” (*Breakthrough Reform #4*). In addition, insurance administrative costs should fall. As in many past reforms of payment systems (e.g. the shift to DRGs) initial payments to the new entities should be generous, so that these organizations can consolidate, and get their own systems up and running.
- 9) **Addressing the “Chronic Continuum”.** Quality and cost are most at risk for patients with a very few number of high-cost, high-risk chronic conditions. Specifically, 5% of Medicare beneficiaries consume 43% of medical expenditures, and the top 10% of beneficiaries account for 62% of costs. No cost reduction initiatives will be effective if we overlook or under invest in chronic care coverage and design.

- 10) **Significant Benefit with Minimal Upheaval.** These changes leverage the infamous 80/20 rule in healthcare – addressing 80% of the quality, access, and cost challenges, while requiring minimal turmoil within the current system. Although further reaching proposals could be introduced, the amount of benefit would be small as compared to the challenges and problems that would need to be overcome to achieve those minimal benefits.

A (brief) Recognition of the Necessary Politics of Passing Reform

Politics is the art of achieving the possible.

- 1) By widening the focus from **Cost & Access** to a three-part agenda of **Cost & Access & Quality**, the tenor of the debate will shift. Current opponents to reform (stakeholders in the status quo) normally try to “own” the quality agenda, arguing, “*Quality will be undermined if costs are trimmed.*” Although this is inherently false, the fear this creates swings public sentiment away from reform. Transparency regarding the true lack of quality – large numbers of inappropriate deaths, injury, and unnecessary care -- across healthcare will help to keep the reform agenda on track. If the debate is focused on guaranteeing quality – and highlighting the scarcity of quality today -- the public is far less likely to oppose reforms.
- 2) Fewer oxen are to be gored with this reform. The key to healthcare reform is to avoid a massive convergence of anti-reform interests.
 - a. Hospitals should be in favor of this proposal – as long as their transitions are supported. This would leave the most visible healthcare entities across the nation in favor of reform.
 - b. Doctors will protest the loudest, but if current quality problems (especially those caused by the hospital/doctor divide) and the potential for a solution are well publicized, this argument will be muted. Furthermore, if well positioned, it could be argued that some physicians might actually be in favor of this proposal. The new “Qualified Integrated Entities” should be able to lower costs faster than CMS lowers price. This will allow physicians to reap additional “bonuses” or salary from the combined entity.
 - c. Insurance companies would benefit from this proposal – their payment systems would be simplified if they follow the CMS lead, and their costs would come under control just as the government’s costs are better controlled.
 - d. Since choice of doctor could be guaranteed, the public would be less likely to protest these changes. Reducing the complexity of Part A and Part B would be a welcome change for seniors. If Part D could be folded into the system, it would keep the public even happier.
 - e. Non-physician providers (physician assistants, midwives, nurses, etc.) should favor this proposal because their involvement in a healthcare system with a consolidated payment structure would likely expand. As care is shifted to these non-physician providers, their stature in the delivery of care would improve, and even their income levels might increase as they become more in demand.

- f. Businesses should favor these concepts because the current flexibility of the healthcare system is maintained, and yet costs and complexity will be more controlled. Most business leaders are not asking for wholesale upheaval within healthcare, but they are asking for cost controls and value for the money they spend. These proposals are incremental enough to calm business fears and yet extensive enough to deliver measureable and significant results.
 - g. Local communities are unlikely to oppose these reforms because the economic engine that healthcare represents in many cities is preserved. Healthcare is often the largest employer in a region and any proposals that are introduced will need to protect that economic base. Although these proposals should reduce per unit costs, total access is expanded. The net result is that the healthcare **business** is preserved while it is simultaneously brought in for a “soft landing”.
- 3) Reforming current institutions will not draw the fire and wrath that creating new bureaucracies, new government programs, and/or new services tends to draw. Medicare is well accepted and entrenched. Making this system more efficient will not be viewed as “socializing medicine” nor as driving a wedge between provider and patient.
- 4) Many of these reforms are technical in nature and confined to the inner workings of the health system itself, rather than a complete revision of the social and cultural fabric of the nation’s healthcare network. This allows the health system to “heal itself” from within – becoming more efficient, more focused on quality, and less complex. The changes, therefore, would be more acceptable than massive adjustments to the market that would require the populace to both embrace and comply with difficult changes. Any initiative that narrows the impact of a change to a few, as compared to the many, is more likely to survive the political process.

Closing Thoughts

It would certainly be a bit presumptuous of us to think that we could describe the problems – and the solutions - to the nation’s healthcare ills in a short 30 page brief. We are neither that confident in ourselves nor so boastful in our limited perspectives. Our hope here is to bring some fresh thinking to a problem that has plagued the nation since Truman, and which needs considerable, and constructive change.

Our sincere hope is that this moment in history can be seized. The healthcare problem is vast and the nation is weary of the toll our system exacts upon us all. At the same time, the nation’s appetite for change and leadership in this area is large. We hope these ideas can spur thinking and can nudge the wheels of reform forward. We would be delighted to speak further about these ideas, or our other thoughts on healthcare at any time.

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Prior to his current role, Dr. Hogan was Managing Director with the *Advisory Board Company* in Washington DC, where he spent over a decade overseeing programs for health system executives, insurance companies, nursing executives, physicians, pharmaceutical firms, and medical device manufacturers. Dr. Hogan has worked with over 500 of the preeminent healthcare players in the world, including Kaiser, the Mayo Clinic, Aga Khan Health System, the Australian Health System, Merck, Aetna, Wellspan, and the health delivery systems of the United States Military.

Dr. Hogan began his career teaching at *Harvard University*, where he was an Assistant Senior Tutor, a Dudley Fellow, and lecturer in the History of Science. He is the author *Unhealed Wounds: Medical Malpractice in the 20th Century*. He holds a BA in History from the University of New Hampshire, and PhD in the History of Science from Harvard University.

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Mr. Wagner served 4 terms in the South Dakota House of Representatives, having served as Vice Chair of the Health & Human Services Committee, working on healthcare issues including scope of practice laws, insurance reform, and public health.

Mr. Wagner worked for nearly 17 years in operational management for various manufacturing and distribution businesses, owned and operated a small grocery store business, and was the Executive Director for the Greater Sioux Falls affiliate of Habitat for Humanity. Mr. Wagner earned his Masters in Public Administration from Harvard University, where he was a Bush Foundation Leadership Fellow, and a Lucious N. Littauer Fellow