

The Last Detail(s)

Thomas P. Miller: We are pretty much down to an affinity group, if not friends and family. I cleverly arranged my remarks today to either be at the beginning of the day when you weren't awake yet or at the end of the day when you have dozed off. In the words of a Bob Dylan impersonator at Capitol Steps performance years ago, "I've suffered for my art, now it's your turn." My job description requires me to be somewhat substantive occasionally, so this is kind of what is coming up.

I am a bit more "grunted" than Chairman Bill Thomas is on this issue, and I have a sense of "evitability" as to what may unfold.

So these are The Last Details. Now you have to understand the background on this 1973 movie, it's the story of – and there is an analogy here, I always work it in – two U.S. Navy sailors, one was played by Jack Nicholson. They are assigned shore patrol duty to escort a young sailor to Naval prison. But on their trip to that prison, the prisoner begins to grow on them, and they decide to show him a good time before serving what is in their eyes an unjust sentence of eight years for a minor crime.

What we really have here is a story of a very expensive drunken spree before going to prison. Does it sound like a premonition of the health reform that we're looking at?

Okay, now we will be actually substantive. Everybody says we are too negative. We are not. Yes, you are. Are not. Are too. May be too argumentative, as well.

Propulsion, not Compulsion

But to put a positive case for health reform, there are other things that could be done, for better results. If you thought of using an approach of propulsion rather than compulsion in the mandate field, and if the health services product was of better value, people might be more likely to buy it. They tend to buy other stuff that they like. There's an affordability issue, but it also comes down to, "I don't want to buy what you are offering me."

In the same way, allow people to fill in their own gaps is necessary, because you've got different people with different willingness to pay and time inconsistencies. Everybody's life year is not worth the same, in terms of how people actually lead their lives and how they spend their own money in estimating what matters to them in the course of their lives -- as opposed to more abstract definitions of "quality-adjusted life years." The difficulty in all of these grand plans is the challenge that one man's ceiling is another man's floor, for different folks at different times. If you want to bring people up from the bottom, you're more likely to squeeze down from the top. If you want to leave the top open and uncapped, you're going to have some disparities along the way. So you have to decide what the necessary floor is, but one that does not shut off someone else's ceiling, in spending their own money and seeking better health.

There are ways to have less intrusive near-mandates that aren't mandates - some of them were mentioned earlier today - such as applying what is an imperfect HIPAA standard of protection against risk re-definition if one maintains continuous insurance coverage. It works tolerably well for a small-group market and when one switches back and forth between employers. If you stay continuously covered in the individual market, what would be the problem in protecting insurance policy switchers against pre-existing condition exclusions and

higher risk premiums? They are at least playing in the pool, and they don't have any gaps in coverage.

In the same way, the payment disincentives to not pick up coverage later than one's initial eligibility period in Medicare Part B and Part D basically gets everybody enrolled at the start. Of course, there is a generous subsidy attached to it, but that's the way to coax people toward doing something that you want as opposed to having an ironclad, you absolutely must do this, command. Because after all, if health insurance coverage is so valuable, why don't people want to buy it, unlike other things they are willing and ready to purchase.

Parallel Portals (Information, instead of Regulation)

In the health insurance exchange realm, we are really talking about parallel portals, by using a more information-based platform instead of regulation to inform consumers about available choices, instead of prescribing narrow ones. This would provide several opportunities to find ways to get what you are looking for in the shopping mall of health insurance, but without saying it's absolutely pre-certified and you can only get so many approved choices. However, those information-based choices are going to have to be accountable in the bilateral sense. Having all of the choices in the world with nothing coming back to you in responsibility for the consequences if you make the wrong choice or a different one doesn't really lead to the type of wiser decision making that we are trying to instill.

The exchanges, as we learned earlier this morning, might involve a thin model of doing what's necessary, but not more -- which is what at least is ramping up in the Utah exchange. It is

very much an information-based platform, as opposed to the regulatory/subsidy model of Massachusetts.

So in the two-way street for everyone with accountable choices, you cannot just leave people alone. You've got to facilitate those choices without dictating them. There's a public goods component to putting some of this stuff on the table so people can get closer to finding what they are looking for. It involves the essential generation of at least the data, if not what the data means, that you can't avoid without going through some public mechanism. But if we could spend a little less time telling everybody what they must do, and more time instead helping them find what they want through navigational assistance and real decision support tools regarding the type of preference-sensitive care options into which they sort themselves out, we might get a little bit further ahead in actually giving people what they need and can use effectively. They would comply more with the medical advice they receive and become much more engaged in maintaining and improving their health. It turns out that the level of engagement and patient self-management has a powerful effect on your health.

The commitment to binding pools for insurance depends upon what's the binding agent. I think that Brian Dowd did a very good job of talking about some of those components in that regard. Once people who differ in their preferences and risk tolerances sort themselves out, then let them have a steady, secure choice where they know that the rules aren't going to change in the middle of their commitment. So you need some glue to bind to some upfront ground rules that you are willing to live with, but then public policy should leave the smaller stuff alone. There's important stuff that we need to focus on, but if you try to do everything through overly comprehensive levels of pooling, you're going to miss out on the more important things along the way.

As opposed to trying to make sure that only the absolute perfect product is out there, if we would spend more time at the front end of knocking down the barriers to product entry, we might find out to our surprise that more competitors get into the marketplace with different products. If we wonder why there isn't any competition, it's because we never let potential competitors get on the field to find out the audience that is there for them.

Who's the Boss?

The core issue is, and it's not just Tony Danza's question here, "Who's the Boss?" It's really the ultimate decision and we should not start from the false premise that you are going to be an isolated, atomized individual, who read the entire medical encyclopedia and can do your own surgery on yourself. Everybody is going to need some agents to help them. But the issue is who gets to choose who is going to choose with you. Who are you deciding that you want to enlist as a partner in those types of decisions?

And that comes back, at least at the starting point, to where the purchasing dollar begins. Tax equity, and a defined contribution base for financing of health care provides a foundation, but that's just a start. It doesn't take you all of the way. It does at least begin to realign initial incentives so you can get a more responsive system. Consumer engagement and patient self-management produces better health from greater involvement in almost every study, if you look at it. It's more than how you purchase health insurance. If you've got the incentives right, you begin getting people to think about what they do that is going to affect their long-term health. It's not a spot decision in a spot market. The full cost dimensions of your decisions, as well as

their consequences in your long-term health, come back to you, and you want to pay more attention to them.

We have constant conflict in the tradeoff between customization and standardization. There is no single setting in that regard, but when you lean too far in one direction, you severely sacrifice the opposite one. We are about to lean very strongly toward more standardization than we need while forgetting about the customized value that we'd like to appreciate as individuals.

Elites can inform us as to what are the better choices and what's the better information, but individuals need to decide on what that information presented to them by the elites means. A lot of people don't believe that their healthcare is as bad as they are being told lately by elites. We've got a real mismatch between those two different perceptions, sometimes based on personal experience. You can persuade and convince, but don't dictate.

The larger problem here is where's the trusted intermediary? People don't trust insurers to present these choices to them. They are a little suspicious of what their employer might do with some of this information if it knew everything about their healthcare. They should be more suspicious about what the government would do as their intermediary. The intermediary we don't look at more often is that intermediary who is ... us. We need to intermeditate for ourselves – first dis-intermediate and then find out who you want to go to in that regard. Trust yourself more to make the right choices with others.

Closing the Value Gap

We all talk about improving information incentives; the question is how you get there. And until the Waiting for Godot of information technology arrives, at least decades if not

millennia from now, we're going to have to use what we have, but think of ways by which whatever this current garbage is, it can be somewhat refined. But data needs to be shared and it's more than just what is in the private sector.

We need to measure what matters. We spend a lot of time measuring what we can measure, and it has nothing to do with how people make choices and what they care about. Comparative effectiveness can inform if it just reports, but then let's people decide -- as opposed to having those decisions made for them externally. Pay-for-value differentials have a limited impact, but at least they provide a little bit of a signal on that front.

We're going to have to come to terms with the fact that Medicare is the big player in this field, it's not going away. Nobody else is getting out in front. So the Medicare program is going to lead and leverage others, for better or for worse. We should not put our hands up, saying "Oh my gosh, I'm shocked that something was done" in that regard, because Medicare has shaped most of the modern U.S. healthcare system, for better or for worse. We could help it do it a little bit better.

This should be a team effort, but not with the government and the payers on the insurance side calling most of the shots. If you think about it, if we can get the various types of providers, patients and the payers talking to each other rather than just to the politicians, they will recognize that they have more common interests in getting a better product, and we might actually get the type of system-ness that is virtual rather than dictated.

Realigning the Public/Private Balance

We can reduce the potential for overreaching by politicians and regulators by focusing on what we want as results, without dictating what the method is to get there. This means relying on a little bit more of an open architecture that focuses on determining “Are the health outcomes better? What are the total costs?” But we should not try to design an entire delivery approach or the equivalent of a manufacturing process.

The challenge of modernizing public programs within willingness to pay recognizes that, at the end of the day, despite all of our dreams of promising “high-quality” care for everybody, affordability will trump comprehensiveness when people are actually paying some of the money as their own. Insurers are suffering from a serious identity crisis. I think they have resolved it, perhaps, in the wrong direction, to become more like price-taking subsidiaries for the federal government, but they ought to think more often about being market-making agents for differentiated-value offers presented to the ultimate end-user, the consumer.

Stronger Incentives

So if we are going to have stronger incentives, what would they really be? If you are going to make differential payments, you can try to just provide more to those who are the very best or nothing to those at the very bottom, and maybe that is as much as the data can allow us to do -- to go after the outliers. But in a better world, you would provide some incentives for relative improvement. Not everyone is going to be the best or perfect, but most can get better. That’s a problem of granularity and precision, but it suggests where the actual signals should go.

Smarter cost sharing also is talked about increasingly, but not applied as much in practice. My understanding is that the definition of a value-based benefit too often is when someone else pays for everything and we call that value, but there actually are instances where paying less for it might actually improve value.

As to targeting incentives to encourage better health behavior, we dance up to this and then we pull it back, because it's said to be wrong to charge people different premiums, yet we then say, "Oh, we should provide some type of sanctions against you for doing the wrong thing." It might actually work better to internalize those incentives and disincentives more directly, within the overall price of an insurance benefits package.

Expanding the toolkit means beginning to deal with not just financial incentives alone, but thinking about the entire arsenal of health decision making factors might fit together better over time. The goal is to look beyond the immediate moment or what pays off in the narrow context of year-to-year insurance premiums, so that we can develop longer time horizons for decisions. The scope of what we use as tools must go beyond just health services or what is covered in the insurance plan, because many other factors can influence our long-term health.

Targeting and Re-Targeting

As much as some would imagine, we really can't pay for everyone else, or we will all be poorer for it. But we should, most of all, protect the vulnerable first. And that means actually paying for this societal commitment, as opposed to just talking about it.

People say it's too expensive to pay for the high cost of low-income/high-risk people. Well, guess what? It doesn't get cheaper by subsidizing even more people beyond that. We

should make executing this core policy objective more transparent and direct. A fully-funded guaranteed access plan (GAP) that subsidized most, but not all, of the higher health insurance costs of those individuals determined to present the most expensive health risks, yet command the fewest economic resources of their own, was estimated to cost about \$20 billion a year in federal funding last year.

Thinner, but value-driven, coverage remains the broader, more affordable route to travel. And by the way, while we're plowing all of our healthcare dollars into the depreciated human capital base above age 65, we might want to consider investing some more of it instead in the next generation. There are some significant opportunity costs in that tradeoff, because it's the younger folks who are going to have to create the new products, get the higher-paying and more productive jobs, and pay for all of our "guaranteed" benefits when we are sitting around as retirees, saying "Why don't you get my check in the mail?"

Better Starting Points

We are going to have to deal with shortcomings of our healthcare delivery system more honestly, rather than assert that it's excellent and our own personal physician is always wonderful as well. As much as we might change the financing that influences patient demand on the margin and also might reduce a little bit of total expenses on the administrative cost side, almost all of the costs of health insurance come from the health care services that actually get delivered -- what it costs and why it could have been more or less. And we do have some notable problems in terms of too much high-cost/low-value care that drives most of the costs in the system. So even though it's a very limited tool, and there are many challenging startup

problems in executing it, beginning to measure and disseminate the relative performance of accountable providers is very necessary.

Some providers are at a big aggregated level (like hospitals and large medical groups, but given our fragmented system, you may be dealing with one doctor at a time, as imperfect as measures at the individual physician level may be. Because that is who people actually engage health care decisions as patients, as opposed to thinking the system is uniform so that wherever I go to for medical assistance, it's going to be the same quality and efficiency regardless of what happens inside of the big-box store at which I start.

We need to change the incentives to spend smarter, treat smarter, and get the job done earlier rather than later. It doesn't mean to do everything in medical treatment that's possible, but to do what is needed at the time.

Producing better health outcomes, rather than just more health services is the goal – at least for real patients if not for Washington policymakers. We can do better.

Beyond Health Insurance

A large factor underlying overall health care costs still involves the patient and consumer side. What is coming into the healthcare system, in terms of the future trajectory of the demand for medical care? In trying to adjust that future demand equation, it's not just a matter of saying we're going to make it so costly that you will just go away and never be treated. Instead, the key variables involve how did you end up developing this condition? Why are you healthy or less healthy? That's what loads into the potential base of demand for healthcare services. If you've got an expensive system, you're just feeding and priming the pump by having more

people presenting with an initial set of complaints and ambiguous symptoms for which the delivery system's response is, "Well, maybe we could diagnose this or maybe we could test you five times over, because you're at least a plausible target for those medical interventions." So staying healthy, before you get the urge or the need to go to the doctor's office would help a lot.

We need stronger tools in this regard than just insurance expansion and more investment in current medical services delivery to improve overall population health. Most people know this, but then they move right off that page and forget about it. We keep obsessing in public policy about the coverage and financing of health care, even though the share of our lifetime health and life expectancy that is due to the variation in health services quality and the availability of it is a fraction of all the other factors that get loaded into all the causes of death and long-term chronic conditions. Many of those later conditions are baked in the cake with a long-tailed trajectory before patients ever engage our very expensive "fix me up at the last minute" medical system.

That's why changing the time horizons for making health care decisions is so important. To deal with that, we will have to get out of the medical box and its various silos. We need to think more about how people make their decisions. Education is a crude proxy for it; we certainly continue to make a lot of mistakes in the educational policy field, as well as in health policy. But people who have more education, as we crudely measure it, end up being healthier. They make better decisions and end up with better long-term health.

It all starts very much in early childhood; there are some necessary interventions and investments we should and could enhance there. Those early developmental experiences will show up in one's health 50 or 60 years later. We didn't just get chronic conditions overnight,

they were shaped and started a long time before, they just seem to suddenly show up more visibly now.

Decision support, brought down to the level at which it means something to a patient, is important because there are a lot of different pathways of treatment that could come out of that. Navigational assistance for health care consumers trying to cope in a very bizarre, complex healthcare system would be much more useful to them than having another round of mandates or a thicker set of rules imposed on third parties, as opposed to giving consumers an informational leg up in finding what they want.

The Urgency of First Discovering What Works

So we have all these theories, all these grand ambitions. Could we try to first actually demonstrate the “savings” before we spend them all in advance? Some of this stuff will work and we need to try all, or most of them, out to some degree now. However, many of the policy proposals and reform concepts are not going to pay off in the short run. We will need to develop a better evidence base for them, before we can assume that we actually have the money to spend that other people like to presume will be available.

We need to focus today, if not yesterday, on the starting path to long-term solutions, not short-term fixes. With a bit more of an open architecture, where you don’t pour in the concrete of fixed public policy on the legislative front.

Slowing down the current health reform express train we are on in Congress this year, and rerouting the tracks, is the better way to go. Remember, you can always “wait till next year”

for the next “once in a lifetime” opportunity. It happens every year in Washington, where there should be no fierce urgency of “right now” before you know what’s going on.

We saw this once before, 20 years ago. It turns out that politicians seem very bold, until they get a little bit of negative feedback at the grassroots. Note this photo of Congressman Dan Rostenkowski, then-chairman of the House Ways & Means Committee, getting in touch, up close and personal, with some of his angry constituents in 1989 after the Medicare catastrophic legislation was passed. It had a shelf life of a little bit less than a year, and never quite got to the full implementation stage. So I wouldn’t recommend going to the precipice and then trying to dial it back, but things are not always fixed in concrete.