COMPTROLLER GENERAL'S

FORUM

HEALTH CARE

Unsustainable Trends Necessitate Comprehensive and Fundamental Reforms to Control Spending and Improve Value

May 2004

GAO-04-793SP

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May 2004

HIGHLIGHTS OF A GAO FORUM

Health Care: Unsustainable Trends Necessitate Comprehensive and Fundamental Reforms to Control Spending and Improve Value

GAO Accountability • Integrity • Reliability
Highlights

Highlights of GAO-04-793SP

Why GAO Convened This Forum

Unrelenting growth in health care spending has put pressure on policymakers to seek health care system reforms. The stress comes partly from a wide gap in expectations between what health care Americans want and what the nation can afford and sustain. GAO's Health Care Forum was held on January 13, 2004, to find ways to elevate the nation's understanding of health care cost, access, and quality challenges. Forum attendees included a select group of experts, business leaders, and public officials.

The forum's plenary speakers discussed issues associated with health care costs and value, including spending drivers, long-term affordability, and the effect of differences across the country in medical practices. Participants in breakout sessions led by the forum's faculty of experts deliberated on the merits of the various health care reform strategies, including

- focusing on consumer cost sensitivity,
- targeting high-cost patients,
- reducing unwarranted variation in medical practices, and
- managing technology to control spending growth.

GAO has developed a series of questions to evaluate all health care reform proposals, based in part, on the results of this forum.

www.gao.gov/cgi-bin/getrpt?GAO-04-793SP.

To view the full product, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7101 or steinwalda@gao.gov.

What Participants Said

The forum's plenary speakers made the following observations regarding health care costs and value:

- *U.S. wealth and other factors drive health care spending*: A nation's wealth is the principal driver of its health care spending. However, wealth alone does not explain the high level of spending in the United States. Other influential factors include the pluralistic organization of the U.S. health care system and ambivalent attitudes toward rationing health care. While health care spending appears affordable for another decade or two, added spending over time will draw resources away from other economic sectors and could induce adverse economic implications for government, individuals, and other private purchasers of health care.

- *Unwarranted variation in medical practices nationwide points to quality and efficiency problems*: Much of the nationwide variation in use of medical services has been attributed to differences in an area's resources and capacity to provide health care. Despite the greater volume of care provided to patients in high-spending areas, they do not have better health outcomes or experience greater satisfaction with care. Payment reforms can foster delivery of care that is clinically proven to be effective. In addition, health care spending can be reduced by identifying and rewarding efficient providers and encouraging inefficient providers to emulate best practices.

At the forum's breakout sessions, participants discussed several promising cost containment and value enhancement strategies. The sessions focused on the merits and drawbacks of efforts to (1) make consumers more conscious of health care costs, (2) coordinate care for the nation's costliest patients, (3) hold the appropriate parties accountable for the costs and benefits of their clinical decisions, and (4) ration technology without denying needed care. A common theme emerged from the four groups: namely, efforts to reward efficiency and achieve better health outcomes are dependent on a much more highly evolved information infrastructure than exists today. Collecting and maintaining the needed data would require political and financial support and a central, independent mechanism for setting standards and policies. Such structural changes are likely to take years to develop, but initiatives are under way to put promising strategies into practice. Commitment by all interested parties and political will are needed to achieve meaningful and sustainable results.

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Introduction from the Comptroller General of the United States

In carrying out GAO's mission to help the Congress examine government spending and its fiscal sustainability over the long term, I am acutely mindful of the extent to which public programs financing health care—particularly, Medicare—face serious challenges. Since the early 1990s when I served as a trustee of Social Security and Medicare, I have been concerned about the Medicare program's fiscal health and long-term sustainability. My concerns have heightened as I examine GAO's long-term budget simulations, which show a large and growing structural deficit due primarily to our imminent demographic tidal wave and rising health care costs. I am mindful, too, that the challenges posed by these trends affect public sector programs at all levels of government, especially the federal and state levels. In addition, employers and other private purchasers of health care services are finding that increasing health care spending poses a threat to their competitive position in an increasingly global market. Furthermore, rising health care costs have implications for overall tax revenues and individual employee cash compensation levels.

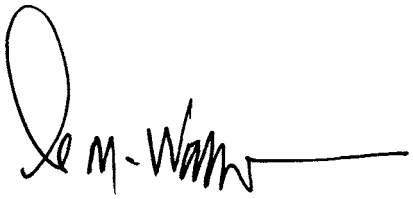
Unrelenting growth in health care spending has put pressure on policymakers to seek fundamental health care system reforms. Part of the stress comes from a wide gap in expectations among patients, providers, and payers: what patients and providers expect is not well aligned with what health care programs are able to deliver. The public and private sectors can both play an important role in educating the public about the differences between wants, needs, affordability, and sustainability at both the individual and aggregate level.

In this regard, GAO's Health Care Forum was held on January 13, 2004, to find ways to elevate the nation's understanding of health care cost, access, and quality challenges. (See app. I for the forum's agenda.) Forum attendees included a select group of experts, business leaders, and public officials, who discussed the challenges associated with financing and delivering health care both now and in the future. (See app. II. for a list of participants.) Distinguished economists, practitioners, and other leading health care authorities served as faculty for the forum's plenary and breakout sessions. (See the selected bibliography of pertinent articles and publications by the forum faculty.)

These proceedings showcase the numerous and complex issues that must be addressed as we seek viable options to reforming the nation's "at-risk" health care system. Convening discussions on these issues is a first step toward obtaining public acceptance of the need for comprehensive and fundamental changes. The next step is for the public, through open

dialogue, to encourage elected officials to address these issues promptly, directly, and effectively.

I wish to thank all the forum participants for taking the time to share their knowledge, insights, and perspectives. We will use the knowledge gained from the day's deliberations in our discussions with Members of the Congress. I look forward to working with the forum's participants on important health care system reform issues in the future.



David M. Walker
Comptroller General
of the United States

U.S. Health Care Has Not Achieved Sustainable Cost, Broad Access, or Good Quality Systemwide

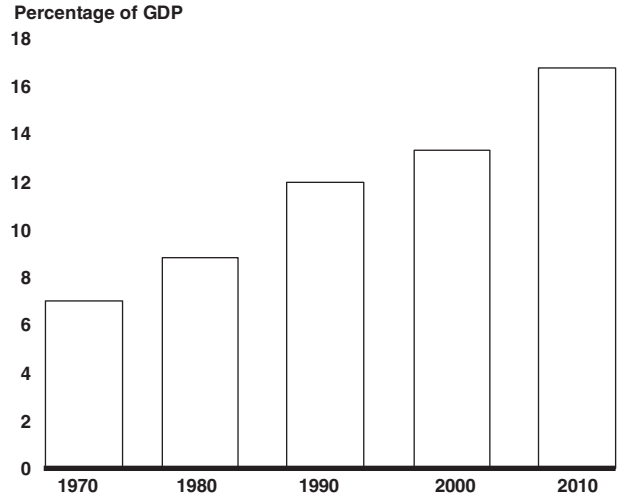
Comptroller General Walker opened the forum with a presentation entitled "Health Care System Crisis: Growing Challenges Point to Need for Fundamental Reform." In essence, he noted that the U.S. health care system is undergoing a period of growing stress. In today's health care sector, there are few incentives for providers and consumers to be prudent in their ordering and use of health care services, too little transparency with regard to the value and costs of care, and inadequate accountability to ensure that health care plans and providers meet standards for appropriate use and quality. Both the public and private sectors are facing major challenges with regard to three fundamental and interconnected dimensions of the health care system—cost, access, and quality. Specifically, rising costs are becoming unsustainable, some Americans do not have access to basic care, and quality of care is uneven across the nation. The following are highlights of the Comptroller General's presentation.[1]

Health Care Expenditures Are Escalating

Past cost containment efforts have not halted the rise in overall health care spending. From 1990 through 2000, spending from all sources—both public and private—nearly doubled in nominal dollars from about $696 billion to about $1.3 trillion. From 2000 through 2010, rapid growth is expected to again double spending to an estimated $2.7 trillion in nominal dollars. The rapid growth in health care spending means that an increasing share of the nation's output, as measured by gross domestic product (GDP), will be devoted to the production of health care services and goods. In 1970, health care spending represented about 7 percent of GDP. By 2010, that share is projected to reach about 17 percent of GDP. (See fig. 1.)

[1] The figures in this section are based on the most recent data available at the time of the forum—January 2004.

Figure 1: National Health Expenditures as a Percentage of GDP

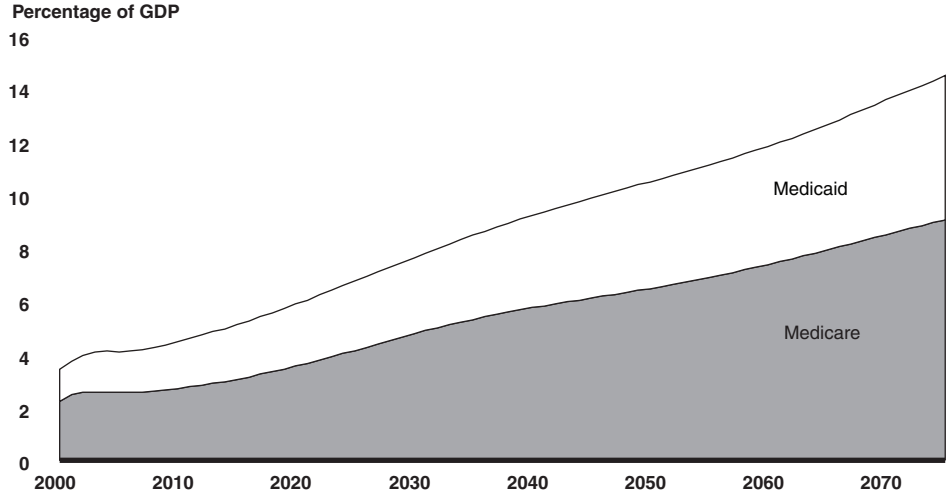


Sources: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis.

Note: The figure for 2010 is projected.

In particular, public program obligations will be unsustainable for future generations of Americans. For example, by 2050, the ratio of workers to pay for each Medicare beneficiary will have dropped from about 4 to 1 today to just about 2 to 1. In addition, Medicare and Medicaid will have more than doubled their share of the economy. (See fig. 2.)

Figure 2: Medicare and Medicaid as a Share of GDP

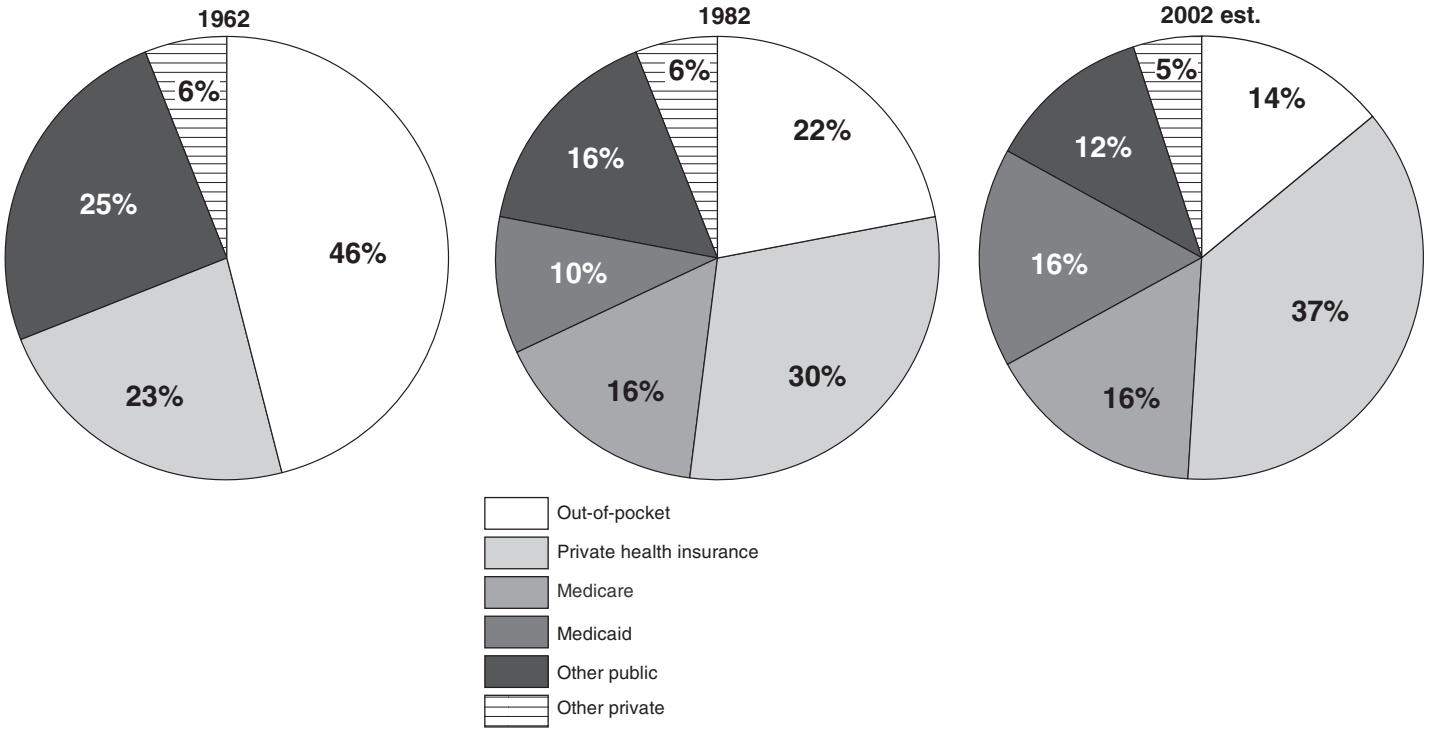


Sources: Centers for Medicare & Medicaid Services, Office of the Actuary; and the Congressional Budget Office (CBO).

Notes: Projections based on the intermediate assumptions of the 2003 Trustees' Reports, CBO's August 2003 short-term Medicaid estimates, and CBO's March 2003 long-term Medicaid projections.

At the same time that health care spending has increased, consumers have become more insulated from these escalating costs. In 1962, nearly half—46 percent—of health care spending was financed by individuals out of their own pockets (see fig. 3). The rest was financed by a combination of private health insurance and public programs. By 2002, the amount of health care spending financed by individuals' out-of-pocket spending—spending at the point of service—was estimated to have dropped to 14 percent.

Figure 3: Composition of Spending on Personal Health Care Services, Selected Years



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

Notes: The figure for 2002 is estimated. Out-of-pocket spending includes direct spending by consumers on coinsurance, deductibles, and any amounts not covered by insurance. Out-of-pocket premiums paid by individuals are not counted here but are counted as part of private health insurance.

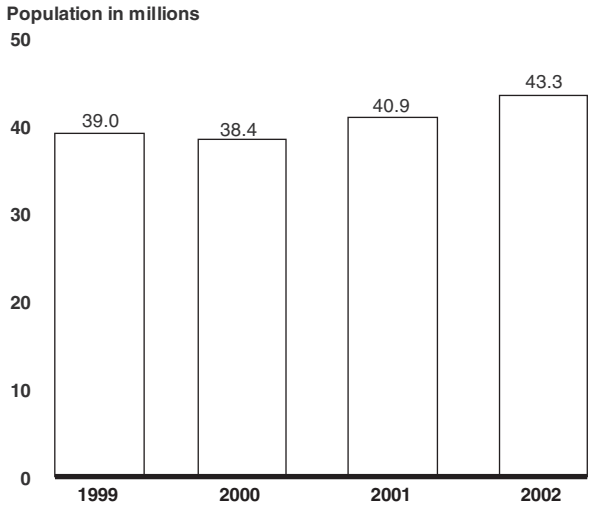
Tax preferences also shield individuals with health insurance from the full brunt of health care costs. Tax considerations encourage employers to offer health insurance to their employees, as the value of the premium is excluded from the calculation of employees' taxable earnings. Moreover, the value of the insurance coverage does not figure into the calculation of payroll taxes. These tax exclusions represent a significant source of forgone federal revenue—over $100 billion—masking the full cost of providing health benefits. Tax preferences work at cross-purposes to the goal of moderating health care spending.

To moderate health care spending in both sectors, we will need to look at broad payment system reforms. For both public and private payers, containing growth in health expenditures will be an abiding 21st century challenge.

Access to Basic Health Care Coverage Is Lacking for Many Americans

Despite higher health care spending, the United States has not achieved broad access to coverage for basic levels of care. Tens of millions of Americans remain uninsured or underinsured. (See fig. 4.)

Figure 4: Number of Uninsured Nonelderly



Sources: GAO, Urban Institute, and the Kaiser Commission on Medicaid and the Uninsured.

Notes: Analyses of the Bureau of Labor Statistics and the U.S. Census Bureau Current Population Survey, Annual Demographic Supplements and Annual Social and Economic Supplement. Figures for 1999 through 2000 are from the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured. The figures for 2001 through 2002 are from a GAO analysis of the Current Population Survey.

Most nonelderly Americans without health insurance are lower-income working age adults. Many more individuals will become uninsured as states struggling with record budget shortfalls cut Medicaid enrollment. Most troubling is that health insurance may be out of reach for many of those who need it most—individuals in poor health. Even among insured individuals, coverage is uneven. Many of these individuals find that important services, such as long-term care and prescription drugs, are not covered or the coverage they have may be substantially limited.

Gains in Health Status and Quality Are Uneven

Although increased health care spending has likely led to much of the improvements in life expectancy and mortality, the United States continues to lag other nations in these and several other outcome measures. In 2000, the United States had an infant mortality rate of 6.9 deaths per thousand live births. This was 23 percent higher than the infant mortality rate in the United Kingdom and more than twice as high as the

rate in Japan for that same year. The United States also exceeds other industrialized nations in the number of potential years of life lost, which is an indicator of premature mortality and preventable deaths.

The United States has fostered quality of care through investment and achievement in medical science. Although advances in medical technology have unquestionably provided medical benefits, consumers are not as informed about the costs and benefits of health care as they may be about other goods and services. For many treatments, experts have developed a consensus on recommended use, but many patients do not receive these treatments at the prescribed frequency. Similarly, some services are overprescribed, providing little benefit and adding unnecessary costs to the health care system. Finally, higher health care spending has not translated to reduced medical errors. An oft-cited study by the Institute of Medicine estimates that deaths due to medical errors in hospitals are higher than deaths caused by automobile accidents, breast cancer, or AIDS.

The growing challenges in the U.S. health care system point to the need for both comprehensive and fundamental reform, which grows increasingly acute as the nation's long-term fiscal imbalance worsens. Thus, the issues of rising costs, inconsistent quality, and uneven access will need to be addressed simultaneously with system reforms and federal leadership on all fronts.

Containing Costs and Enhancing Value Are Key Challenges Facing the Nation's Health Care System

Why does health care spending in the United States consume a greater share of the nation's economy than in other countries? Is this level of spending affordable and sustainable? What is the value of the health care the nation purchases? How can spending be reduced without sacrificing value? These questions were the subject of the forum's morning plenary sessions on health care cost and value. Presentations were given by Dr. Uwe Reinhardt of Princeton University and respondent Dr. Alice Rivlin of the Brookings Institution and by Dr. John Wennberg of Dartmouth Medical School and respondent Dr. Arnold Milstein of the Pacific Business Group on Health. The following is a summary of these presentations.

U.S. Wealth and Other Factors Drive Health Care Spending

Dr. Reinhardt presented his analyses of data from the Organisation for Economic Co-operation and Development (OECD), which show that U.S. spending on health care per capita continues to outpace other industrialized nations. For example, Canada, a country with a fairly similar health care delivery system and similar medical practices, spent

only 57 percent as much per capita as did the United States in 1999. Although the aging of the population is often cited as a driver of national health care spending, this claim is not supported by the data. According to Dr. Reinhardt, a nation's wealth, as measured by GDP per capita, is the chief health care spending driver. A nation's per capita GDP explains about 90 percent of health care spending differences across nations. Essentially, ability to pay drives consumption.

However, Dr. Reinhardt noted that per capita GDP does not account for as much of health care spending in the United States as in other countries. Per capita GDP in the United States explained only $3,300 of the $4,800 U.S. per capita spending on health care in 2001. Other influential factors include the organization of the U.S. health care system and attitudes toward health care rationing.

Dr. Reinhardt observed that the U.S. health care system is highly fragmented among multiple payers, hundreds of thousands of providers often functioning in isolation, and patients with different levels of private and public coverage or no coverage at all. Such complexity and fragmentation drives up administrative expenses as well as care costs. Another contributor to spending, he continued, is the unwillingness of Americans, most of whom are insured, to ration health care. Good health insurance affords millions of Americans easy access to world-class health care facilities. (As an aside, he noted that these advantages have not translated into superior health status.) In principle, neither the public nor its policymakers are willing to deny care, regardless of whether it adds value to the individual or society. For example, he noted that the value of doing procedures such as hip replacements on patients in their mid-80s and older is highly questionable. For the significant minority of uninsured Americans, however, Dr. Reinhardt observed that the rationing of health care by price and ability to pay is manifest, especially for primary and secondary care, if not for tertiary care.

Dr. Reinhardt explained why population age is not very significant as a cost driver of health care spending systemwide. The United States is a relatively young country compared with other OECD nations whose spending per capita on health care is significantly lower. Moreover, the growth in the proportion of the population over age 65 (an expensive demographic group in terms of health care) will be gradual, projected to rise less than 10 percentage points by 2050. Several simulations have shown that age and gender account for only a small percentage of predicted annual growth in spending on health care. Other research shows that much of the annual growth in national spending on health care

is driven by the same factors that drive increased per capita spending across all age groups.

Dr. Rivlin provided commentary on Dr. Reinhardt's presentation. On the topic of rationing in the United States, Dr. Rivlin noted that organ transplants should not be overlooked as one example: potential recipients of organ transplants are ranked in priority order according to clinical criteria. Nevertheless, the United States does not ration health care extensively, she noted, because we have not reached a point where the money spent on health care is considered not worth the investment. We are continuing to see gains as people are living longer and leading less impaired lives. On the topic of the aging population as a cost-driving factor, Dr. Rivlin pointed out that from a federal budget perspective, aging will have a significant impact. In particular, an increase in the very old population (people in their mid-80s and older) will be important because of their need for long-term care. In 2030, only the leading edge of baby boomers will have reached age 80, portending significant cost implications for Medicare and Medicaid in the years that follow.

Unexplained Variation in Medical Practices Nationwide Points to Quality and Efficiency Problems

Americans' use of and expenditures for health care services vary widely by geographic region. Much of the data showing regional differences was developed from Dr. Wennberg's "small area analysis" research, which divides the country into 306 geographic areas (called hospital referral regions). Noting that the Medicare patient populations in these areas differ little in terms of illnesses, Dr. Wennberg attributes much of the variation in use of medical services to differences in an area's resources and capacity to provide health care.

To explain further, Dr. Wennberg divides medical practices into three categories of care: effective, preference-sensitive, and supply-sensitive.

- *Effective care* refers to clinical services that have been proven to be efficacious with high benefit-risk ratios. As such, these services should be provided to patients whose diagnoses indicate the need for them. Annual eye exams for diabetics is one example of effective care. Dr. Wennberg's research shows that from 1999 to 2000, 30 percent or more of diabetic Medicare patients did not receive these medically necessary eye exams, illustrating one of many instances of "underuse" of effective care across the United States.

- *Preference-sensitive care* refers to clinical services that meet several conditions: two or more valid treatment options are available, the options

carry different risks and benefits, and patient preference should determine which option is selected. Examples of preference-sensitive services are coronary artery bypass grafting (CABG) and back surgery. Misuse of these services occurs when patient preferences are not respected in determining the choice of treatment.

- *Supply-sensitive care* refers to services for which there are few clinical guidelines so that the per capita use of these services is influenced by the available supply of resources. Among the Medicare population, most supply-sensitive services are used in treating patients with chronic illness. They include hospitalizations and use of intensive care units, revisits to doctors, referrals to specialists, and use of diagnostic tests and imaging procedures. Dr. Wennberg's research shows that about 50 percent of the variation in discharge rates for patients hospitalized with any medical condition is explained by the supply of acute care beds. He noted that overuse of supply-sensitive care accounts for most of the variation in overall Medicare spending.

Consistent with Dr. Reinhardt's analysis, Dr. Wennberg's studies show that greater per capita spending buys more supply-sensitive care. Areas with above-average spending have similar patterns of underuse of effective care and overall rates of expensive preference-sensitive care, including elective surgery. In other words, spending more per capita does not buy greater quality. What greater spending purchases is more frequent use of supply-sensitive care in managing patients with chronic illness: more hospitalizations, more stays in intensive care, more visits, and more tests.

The critical question is this: does greater spending purchase better health? Despite receiving a greater volume of care, Medicare populations living in higher-spending areas compared to those living in lower-spending areas do not have better health outcomes or experience greater satisfaction with care. In fact, populations living in high-spending areas appear to experience slightly worse outcomes. The results of this research suggest that, if we can achieve more consistency with medical standards of practice, vast potential exists to reduce spending without harm to patients while making gains in health outcomes.

Payment Reforms Can Foster Delivery of Effective Care, Leading to Reduced Health Care Spending

To achieve a health care system that delivers more effective care—medical practice based on proven efficacy—our public and private payment systems need to be reformed.

Dr. Wennberg offered a working hypothesis for he what terms "value health purchasing." Health care spending can be reduced, he contends, using a three-pronged approach:

- *Identify efficient providers*. Cost and utilization data can identify health care organizations (for example, hospitals and associated physicians) that use fewer supply-sensitive services than their peers in treating patients with chronic illness.

- *Reward efficient providers*. These are providers who also address underuse of effective care and misuse of preference-sensitive care. For example, payers can reward providers who adhere to practice guidelines for effective care and ensure that patient preferences drive the demand for preference-sensitive treatment options.

- *Encourage inefficient providers to emulate best practices through payment incentives*. For example, to discourage the provision of unnecessary care, payers could compensate providers managing patients with certain chronic conditions by paying fixed per-patient amounts based on historical actuarial costs rather than paying a fee for each service.

Given the extent of variation in medical practices, Dr. Wennberg suggests that the nation's leading medical institutions—academic medical centers—would be a good place to begin the process of improving health care quality and efficiency. He notes that historically, these centers' experience in translating basic science research into clinical practice has been inconsistent and that variations in health care delivery among the centers points to a lack of consensus even among the nation's medical science leaders on the appropriate use of medical care. At the very least, he argues, federal policy should provide incentives for academic medical centers—the facilities that train and prepare health care professionals—to accept responsibility for the scientific basis of clinical decisionmaking.

Dr. Milstein, commenting on this presentation, observed that Dr. Wennberg's prescription for more efficient, higher quality care is consistent with the fundamentals of mainstream industrial procurement practices. These fundamentals anchor the new health care purchasing strategies that large employers are now adopting. They include (1) encouraging patients to use providers that, over time, have been cost-

efficient and have earned favorable quality ratings and (2) rewarding well-performing providers for reaching world class benchmarks of longitudinal cost-efficiency and quality. He concluded that an ideal system is one in which incentives encourage providers to be highly self-conscious about their performance shortfalls and consumers to be performance-sensitive about their choice of providers and treatment options.

Participants Discuss Strategies for Controlling Costs and Enhancing Value in Health Care

Following the forum's plenary sessions, participants attended one of four breakout sessions. At these sessions, they examined cost containment and value enhancement strategies that underlie many recent proposals to reform health care. The breakout sessions had the following themes:

- Does a Focus on Making Consumers Sensitive to Health Care Costs Hold Promise for Containing Costs and Enhancing Value? (led by Paul B. Ginsburg, PhD)
- Can We Control Costs and Enhance Value by Targeting Patients at Greatest Risk for Health Problems and High Expenditures? (led by Elizabeth A. McGlynn, PhD)
- Can Payment Reforms and Other Structural Changes Bring About Reductions in Unwarranted Medical Practice Variation? (led by Mark D. Smith, M.D., MBA)
- Is It Feasible to Control Spending without Compromising Scientific Gains by Managing Medical Technology and Innovation? (led by Stuart H. Altman, PhD)

The following is a synthesis of these discussions.

Does a Focus on Making Consumers Sensitive to Health Care Costs Hold Promise for Containing Costs and Enhancing Value?

Many view "consumer sensitivity" to health care costs, along with increased access to user-friendly information, as key to reining in rising health care spending. Proponents of this view contend that insured consumers are insulated from the true costs of care and the information needed to make judicious decisions about the care they buy is essentially lacking. Participants discussed whether, under these circumstances, a focus on consumer health care decisionmaking could help achieve the necessary trade-offs to contain costs and maintain value. They concluded that linking consumer cost incentives to physician performance would be the most effective strategy but would necessitate efficiency measures that have not yet been developed.

Increasing Consumer Cost Sensitivity Has Potential for the Future but Currently Suffers from Serious Data Limitations

Ideally, consumers become more sensitive to the costs of health care when they have incentives to make decisions based on value—the best quality for the lowest cost. Because this strategy depends on good consumer information, its implementation to date has been less than perfect. For example, some employers seek to steer their employees toward choosing the best value health plans, but data on health outcomes and best medical practices as well as an infrastructure to make this information readily available to the public are lacking. One participant gave the example of an employer that was considering offering its employees different cost-sharing arrangements. Under a baseline arrangement, the employer's plan would pay 70 percent of an individual's health care costs and the worker, 30 percent; or the plan would pay 90 percent and the worker, 10 percent, if the individual called a plan-sponsored telephone number before seeking care to get advice and education on appropriate services and providers. A participant noted that this proposal assumes that there are extensive data on services available and the telephone staff can give good advice.

Participants noted that workers may resist employers' efforts to encourage cost-consciousness, as these efforts are seen as cost shifting (increasing workers' share of costs) rather than as a step to improve value. Often the higher cost sharing is a compromise, but participants agreed that until tools are available to assess the quality of providers' care, it is too early to use increased cost sharing as a means to achieve better value.

Consumer Cost Incentives Would Need to Be Modified for Low-Income, Uninsured, and Chronically Ill Populations

Participants also made the following points, suggesting that conventional consumer cost incentives may not make sense for low-income, uninsured, and chronically ill individuals. Little research exists on the effectiveness of cost sharing (such as $1 or $2 copayments) for low-income individuals who are on Medicaid or the State Children's Health Insurance Program (SCHIP) or who are uninsured. Some states' Medicaid and SCHIP programs use scaled-down cost sharing, but there is less interest in cost incentives for this population both because the population is low income and because Medicaid and SCHIP are less constrained to use administrative procedures to control costs. When Massachusetts added a 50-cent copayment per prescription for low-income individuals, the number of people who filled prescriptions in a homeless community plummeted. Participants discussed whether the measures of efficiency should be the same for low-income populations as for others. For example, the time needed to counsel a homeless population on healthy behaviors was much longer than for more affluent populations.

Participants also discussed the nature of cost incentives for chronic care and other high-cost patients. One participant noted that much of health

care spending is by high-cost patients who exceed their maximum for covered out-of-pocket costs. Moreover, many high-risk, chronically ill patients are loyal to certain providers, even if it costs them more to obtain care from these providers. Thus, cost incentives that encourage consumers to differentiate among plans and providers will have a limited effect on the behavior of these high-cost patients. Issues associated with high-cost patients are also discussed in the next breakout session summary.

Incentives Could Be More Effective If Focused on Physicians

With regard to cost incentives, participants agreed that "it's all about the doctor," as consumers' initial decisions about the care they receive typically start with advice they receive from their physicians. Participants discussed importance of focusing on physician performance rather than on hospital performance. One participant suggested developing "fuel efficiency" ratings with information on physicians' costs and quality and translating this information into cost incentives for consumers to choose the more efficient physicians. He said that a few large purchasers are moving in this direction. Another reason to focus on physicians, he said, is that measures of hospital efficiency can be linked to physicians' ratings. For example, some hospitals may charge more than twice as much as other hospitals for an MRI; if these costs were built into physicians' ratings, physicians would be induced to affiliate with the more efficient hospitals.

Participants noted the need to address the reality of patients' strong affiliation with their physicians. A participant shared an example of a Kentucky employer that had provided its workforce information on costs and quality at 14 Louisville-area hospitals; even with such information available, 40 percent of patients the employer covered went to the high-cost, low-quality hospitals. The employer now has plans to link hospital performance information to differential cost-sharing plans, making workers pay steep cost differences if they choose the lower-performing hospitals. According to one participant, the employer in this example has "already lost the battle," because patients typically make hospital choices on the basis of their physicians' affiliation with particular hospitals. As a practical matter, however, he noted that it is easier to get data on hospitals than physicians, which is why many health plans and employers have started with cost incentives linked to hospitals rather than physicians.

Linking Cost Incentives to Appropriate Care Is Difficult without Consensus on What Services and Treatments Are Discretionary

Participants were skeptical about the potential in the near term to develop measures of physician performance, as these measures would require medical experts to arrive at a consensus about whether a given treatment was necessary or elective. For example, as one participant noted, many would agree that the use of Viagra (and drugs like it) is elective and thus a potential candidate for higher cost sharing, but achieving a consensus on other treatments was not as clear-cut. While one participant said any given health problem can be placed on a spectrum, with variable out-of-pocket costs depending on relative efficiency, another responded that this would lead to an "abyss." For example, even erectile dysfunction drugs in some circumstances could be determined to reduce other medical or mental health costs. Similarly, for back surgeries, it is unclear whether "adding two screws to the spine," for example, is an effective treatment. Participants also noted that a good efficiency measure needs to adjust for hospitals or physicians that take high-risk patients or providers will avoid risky patients. However, there is debate on how good today's risk adjusters are and whether, in addition to risk, longitudinal efficiency measures also need to be adjusted for unavoidable social costs, such as uncompensated care, and for training expenses, such as those incurred by teaching hospitals.

One participant noted that health plans already have consumer cost incentives for prescription drugs. Plans can steer their beneficiaries' purchases to specific drugs through the use of a formulary—that is, a list of prescription drugs around which health plans create incentives for physicians to prescribe and beneficiaries to choose. Many plans have three tiers of cost sharing based on a patient's choice to use a generic, formulary, or nonformulary drug. Several participants agreed that tiered cost sharing for drugs was acceptable because having tiers informed the consumer about the drug's relative cost-effectiveness without denying coverage altogether.

Can We Control Costs and Enhance Value by Targeting Patients at Greatest Risk for Health Problems and High Expenditures?

A small fraction of the population accounts for a substantial share of total health care spending, due to these patients' high use of services, the high costs of their care, or both. While some of these people are acute care patients, such as trauma victims or certain newborns, others have chronic conditions, such as renal failure, asthma, and diabetes. Regardless of the source of their illness, these groups of patients have ongoing needs and place continual demands on the health care system. Participants in this session discussed whether strategies targeted at the chronically ill population could lead to reductions in health care spending and quality improvements overall.

A Focused Strategy on Chronic Care Could Improve Value, but May Not Reduce Costs

The group noted that a focus on managing chronic illnesses could improve patients' health care quality for at least two reasons. First, the nation's delivery systems are designed primarily for acute, episodic care, but chronically ill patients need continuous and coordinated care, as well as a focus on preventive services, self-care, and adoption of healthful behaviors. Stated one participant, "The best way to not die of a heart attack is to not have the heart attack in the first place." Second, current research shows that patients do not receive the most effective care known. Work by RAND has shown that appropriate care is provided to patients only about half the time. The current system does not effectively meet the needs of people with chronic illness, and this contributes to less than optimum value for the very patients that rely most heavily on the health care system. Meeting the needs of chronically ill patients could improve the quality of care they receive and their outcomes but could also increase costs. The group recognized that improving value for these patients would require improving quality, decreasing costs, or some combination of both.

The group also recognized that the burden of illness is not the only factor driving health care costs, noting that Dr. Wennberg's seminal work on regional differences in the use of medical services shows that wide variation is not explained by differences in medical diagnosis. Relating this phenomenon to caring for the chronically ill, the group noted the cost and value implications associated with the three categories of care classified by Dr. Wennberg—effective (care proven clinically effective), preference-sensitive (care involving trade-offs because more than one treatment exists and each may result in different outcomes), and supply-sensitive (care based more on the capacity to provide services than on medical knowledge or evidence). On the one hand, the group postulated, policies aimed at managing supply-sensitive care could have the most promise for reducing expenditures but may be the most difficult to implement politically. On the other, policies that encourage the practice of effective care—ideal from the standpoint of quality—could raise spending for some services and lower it for others but would also be difficult to implement, owing to the small number of clinical practices for which there is rigorous established evidence. Following this last point, the group focused the bulk of its remarks on the challenges associated with encouraging effective clinical care.

Systematic Data, Payment Reforms, Health Education, and Authoritative Standards Needed to Achieve Value

The group determined that to achieve a value-driven health care system, it is necessary to have (1) better information about the services provided and outcomes of care to assess value, (2) incentives to provide the most effective care known, (3) public awareness of the impact of lifestyle and personal health behaviors on the costs of care, and (4) an authoritative

source of reference for the public, providers, and payers on what constitutes effective care. These translated into the need to address the following key areas:

- *Systematic data*: Participants noted that better clinical information and better information technology are needed to create incentives, enhance transparency, and ensure accountability in health care. The development of such information involves two steps: (1) information systems would need to be built, perhaps starting with data on high-risk patients whose care by multiple providers would require an infrastructure of compatible systems, and (2) support for the public reporting of information, which would include addressing antitrust laws that now inhibit efforts to share utilization and outcome data on the care delivered by a community's physicians, hospitals, and other health care providers. The group recognized that building an information infrastructure would be expensive and would need to be viewed as a public good and social investment. Ideally, there should be a central, independent mechanism for setting standards, policies, and regulations and public support for developing the infrastructure, although multiple private sector entities could participate in developing the systems. It would be logical to begin the design and development of information systems with a focus on chronically ill patients since they have the most frequent contact with the health system, but over time, the information systems would be diffused to the larger population.

- *Payment reforms*: Participants noted that in the current environment, incentives are lacking to provide certain types of cost-effective care. For example, physicians paid under a fee-for-service arrangement generally need a medical "event," such as a visit or a procedure, to get paid for care. Usually, insurers do not pay physicians solely to counsel patients or coordinate their care, services that are particularly important for chronically ill patients. Furthermore, if a group of clinicians in a hospital want to change a care process, it is difficult to move resources between the different parties that are each paid separately (for example, hospitals and physicians), in addition to the challenge of freeing resources that have already been allocated in line with existing processes. Participants also discussed the need to create financial incentives to foster the use of effective care. For physicians, incentives could include increased payments or loans to reward the use of information technology; for patients, they could include reduced copayments or deductibles to reward good health habits and cooperation in permitting use of personal health care information.

- *Health education*: Steps to improve health quality would need to be accompanied by a sustained health education campaign, such as the one conducted over many years on smoking. People should be made more aware of the need to improve health quality and how their lifestyle and other choices affect the outcomes and costs of their health care. For example, to combat the obesity problem, the public could receive information on the "body mass index," explaining how higher levels are related to costs of care.

- *Authoritative standards*: The group determined that practicing effective, evidence-based medicine and encouraging it through payment reforms required an authoritative body of experts to develop and promulgate standards of practice. These standards, based on science and expert consensus, would guide clinical decisionmaking and payers' determination about whether services claimed were medically necessary. In addition, the standards would be linked to tort reform: as long as the standards were followed appropriately, a clinician would not be subject to litigation. The group believed this standard-setting body should first focus on high-cost, high-use patients and on obvious opportunities for quality improvements. Some participants contended that more than standards are needed to address the problem of wide variability observed in medical practices, as studies by RAND show that even where there are agreed-upon standards, appropriate care is provided only about half the time. Issues associated with medical practice variation are also discussed in the next breakout session summary.

Can Payment Reforms and Other Structural Changes Bring About Reductions in Unwarranted Medical Practice Variation?

Studies show that the rates at which patients receive physician office care, surgical procedures, and hospital care vary extensively across the country without clinical explanation. Health care outcomes—such as mortality, quality of life, and medical errors—similarly vary. Leading experts, such as professors Reinhardt and Wennberg, contend that for much of U.S. health care, supply drives demand. In other words, higher-than-average utilization of a particular procedure may occur in an area where the technology or specialists performing the procedure are in abundance. Dr. Wennberg estimates that such supply-sensitive care accounts for much of the regionally high service use in Medicare and that reducing high use to levels seen in low-use regions would result in about a 30-percent reduction in Medicare spending. Patient preferences for certain procedures and services also contribute to variability in health care use rates. Participants in this session discussed whether better outcome data for providers and patients to make clinical decisions and the restructuring of payment

systems to reward quality and efficiency could achieve desired health care system reforms.

Reducing Medical Practices That Are Inconsistent with Quality and Efficiency Will Depend on Collecting Better Clinical Outcome Data

Participants agreed that the systematic collection of clinical outcome data is fundamental to building a health care system that promotes efficiency, decreases the use of unnecessary procedures, and improves quality. With longitudinal data, analysts can begin to develop quality and efficiency measures that providers, patients, and payers can use to make and reward the best clinical decisions. Better outcome data could, for example, identify which patients are suitable for organized chronic disease management programs and where the provision of unnecessary care could be reduced. Such data could be used to guide patients' health care decisions, particularly when care alternatives are available without a clear-cut choice. For example, one participant contended that less than a third of male patients with severe prostate problems preferred surgery once informed of the risks and trade-offs.

The group also observed that more outcome data could not only help inform case-by-case clinical decisions but also strengthen market forces. For example, making comparative data available to providers and patients about costs and clinical outcomes could help channel patients toward the most efficient practitioners. On this basis, payment systems could be restructured to reward the best value of care. Several participants suggested that providers' payments and patients' insurance copayments could be aligned with quality and efficiency data to pay more for delivering higher quality efficiently. Many managed care plans use such an incentive to contain prescription drug costs: patients can choose to pay more for a branded drug and less for a generic equivalent. Participants suggested that insurers could similarly decrease or waive patients' insurance copayments if they participated in a shared decisionmaking process with their physician and relied on efficacy and quality data in opting for treatment.

Accountability for Clinical Decisionmaking Involves Several Parties to Varying Degrees

The group agreed that effective change strategies will not only require the collection of better health outcome data but will also require that those that exercise control over clinical and cost decisions—health care systems, hospitals, physicians, and patients—be made accountable and rewarded, when appropriate. Participants agreed that assigning accountability for cost and clinical decisions is as challenging as it is important, because there are multiple parties that have decisionmaking control.

- *Health care systems*: Participants noted that variation in the degree to which health care systems are organized makes it difficult to assign

accountability at a "system" level. One participant noted that some health care systems were too loosely organized to permit credible accountability. Another noted that too many of the relevant decisions were controlled by physicians rather than plans.

- *Hospitals*: Participants agreed that in principle, hospitals could be an appropriate party to hold accountable for constraining health care supply in that they hire physicians, "build beds," and invest in technology—all of which offer potential avenues for influencing cost and clinical decisionmaking. If data were available to determine what constitutes an "appropriate hospitalization," a hospital could be paid a fixed amount that reflects the number of hospitalizations expected for its patient base, regardless of how many beds it uses. However, perverse payment incentives and lack of leverage in certain instances suggest that hospitals alone cannot assume accountability for optimal clinical decisionmaking. One participant observed that hospitals generally do not have control over the prescribing behavior of their attending physicians. Participants also discussed the increasing number of procedures—orthopedic surgeries, endoscopies, and mammographies, for example—that are now being done in physicians' offices, thereby decreasing the influence that hospitals have over these and other inpatient procedures. The group agreed that other procedures are performed for which hospitals could be appropriately held accountable for quality or appropriateness, such as CABGs and other surgeries.

- *Physicians*: Like other breakout session participants, this group determined that physicians were the appropriate party to hold accountable for a number of clinical decisions and costs. According to one participant, general practitioners in the United Kingdom receive substantial bonuses for quality and efficiency. She suggested that a similar "pay for performance" model could be applied in the United States, under which physicians who referred patients for fewer procedures that result from excess capacity, such as CT-scans and MRIs, could be financially rewarded. Other participants disagreed and warned that strategies designed to curtail the provision of health care services carry with them the risk of a backlash, if it appears that providers are being rewarded for denying care. One participant asked, "Would people be comfortable paying more for less?" Another participant suggested that doing so would send the wrong message: "Why pay doctors to do things right, rather than not pay them if they do things wrong?"

- *Patients*: One participant noted that although physicians were an obvious party to hold accountable for clinical decisionmaking, patients themselves were important in the process. In principle, if comparative quality and

efficiency data were available to patients, financial incentives, such as lower copayments, could steer patients toward using the appropriate physician, hospital, or health plan. This could result in a spillover effect: as more patients choose these providers, the providers would have incentives to perform better. Another participant noted that the use of data to influence patient choice assumes rational decisionmaking on the part of the patient, but in many cases, acutely ill patients must make decisions quickly that may be more emotionally based. The group agreed that as a practical matter, the lack of adequate comparable data today limits the ability to link incentives to patients' decisions.

Participants emphasized that regardless of who is held accountable for clinical and cost decisions, a "one-size-fits-all" approach to payment incentives will not work. Incentive strategies should be structured differently for inpatient and outpatient services, specialty care and primary care, and other groupings. Payment restructuring would need to reflect variation within the existing payment systems and be tailored to differences among payers—such as Medicare, Medicaid, and private insurance—and their covered populations.

Implementation Issues Make the Prospect of a Value-Based Health Care System a Long-term Goal

Participants noted that a data-driven reform strategy to improve health care quality and efficiency depends on an information technology (IT) infrastructure that is virtually nonexistent today. In particular, the necessary level of technological sophistication to gather, monitor, and securely transmit data does not widely exist at the physician office level. Without appropriate IT resources, office-based physicians are likely to have difficulty expeditiously recording the information that is needed for outcomes research and applying the findings of such research to their own practices. On a systemwide scale, differences in payment methods will require more IT sophistication to implement structural changes.

Is It Feasible to Control Spending without Compromising Scientific Gains by Managing Medical Technology and Innovation?

Policymakers are looking at the role of technological advancements as an important driver of future spending growth. Although some technologies can achieve savings—for example, by reducing hospital stays—the increase in utilization that results from technology advances has generally offset any related savings. Finding appropriate limits on technology development and use is problematic, however, as such limits may deny patients improvements in health care quality, such as life-extending care. In light of these trade-offs, participants discussed the difficulty of assessing technology's net impact on health care spending and the lessons this holds for controlling its use.

Difficult to Determine Technology's Impact on Spending Because Systematic Assessment of Costs and Productivity Offsets Is Lacking

Acknowledging that technological change accounts for a significant share of health care inflation, participants addressed the question, "Have we been getting our money's worth?" The group agreed that technology's contributions over the last 20 years—new pharmaceuticals, diagnostic imaging, and genetic engineering, among others—have been, on the whole, of significant value to the nation's health. However, on a case-by-case basis, the use of high-tech procedures to improve health and prolong life may be of questionable value when the technology to be used is very expensive and odds for the patient to have a good outcome are very low. For example, one participant noted a case in which a 92-year-old cardiac patient underwent bypass surgery and received a heart-valve replacement but died 2 months later from pneumonia. Participants agreed that the general tendency in this country is to treat patients with available technology when there is the slightest chance of benefit to the patient, even though the costs may far outweigh the benefit to society as a whole. Other countries do not spend as much at the end of life. The group also agreed, however, that no one would choose to go back to the 1980s technology over that of today's, despite all its inefficiencies. But, asked one participant, "Can we figure out how to get more efficient?"

The group determined that a big problem in using technology efficiently was a lack of information, developed and disseminated systematically, on which patients, providers, and payers could make good health care and cost trade-off decisions. They noted that progress in the discipline of technology assessment has not kept pace with medical technology advancements. The medical community has not invested in IT—such as the adoption of computerized patient records—despite the potential for patient safety improvements and savings through administrative simplification. The reason, contended one participant, is that market forces have not driven IT investment in same way that they have driven investments in pharmaceutical research and diagnostic imaging equipment. Nevertheless, today's employers, who finance a substantial share of the health care of the privately insured population, are seeking more information on health care technology costs and benefits. At the same time, the technology industry has been thwarting efforts by public payers to assess their products on the basis of cost-effectiveness. Some participants cited the need for government investment and direction, through grants and reimbursement policies. The group determined that without greater transparency and knowledge about technologies' benefits relative to their cost, technology will continue to "test positive" as a major cost driver.

Controlling Use of Technology Faces Barriers to Change

The group noted that the conventional controls to rein in technology use focus on supply, as supply is a primary factor driving health care demand. For example, formularies are lists of drugs developed by health plans to control the use of expensive drugs. Formularies favor the use of the generic equivalents of brand-name drugs on the assumption that generics are, more or less, equally effective and, being less expensive than branded drugs, are thus more cost-effective. Similarly, certificates of need (CON) are a regulatory measure some states use to limit the diffusion of high-tech equipment, such as MRIs and CT-scans. CON requirements enable states to limit expensive technology to a few strategically located facilities and help even out the distribution of resources across locations.

Efforts to use cost-effectiveness as a criterion for deciding when and whether to use medical technology have had mixed success. Participants noted that many entities try to do their own cost-effectiveness analyses, but there is a lot of duplication of effort and their efforts are typically impeded by incomplete or otherwise less than robust data. For example, one participant noted that health plans developing formularies each seek information on the cost-effectiveness of various drugs, but outside of the drug companies, no one—not even the Food and Drug Administration (FDA)—has access to the data needed to conduct these analyses effectively.

Much of the discussion focused on the need for a central function, independent of the industries, that would assess health care technologies beyond the level of the safety and efficacy analyses that FDA conducts. Some participants favored the establishment of a public (that is, government) entity, whereas others supported a public-private partnership, modeled after the National Quality Forum (a consortium of businesses and not-for-profit organizations that do studies on building a "business case" for quality). As part of the discussion of barriers to centralization, several participants cited the reining in or elimination by the Congress of government entities tasked with assessing technology or promulgating practice guidelines, such as the Agency for Healthcare Research and Quality and the Office of Technology Assessment.

The group agreed that a major barrier to advancing technology assessment is the technology industry itself. Better information on cost-effectiveness, participants noted, may not be in the financial interest of a company whose drug or device is not judged cost-effective. Other barriers, a participant noted, come from institutional providers and individual practitioners. Ideally, hospitals and physicians will use quality measurement—outcomes and effectiveness data—to foster best medical

practices. In fact, providing feedback data to physicians—for example, on their prescribing behavior compared to that of their peers—has been a powerful tool in bringing the practice patterns of "outlier" physicians in line with an appropriate norm. At the same time, physicians and hospitals have raised methodological concerns about the soundness of quality measurement initiatives, given that flaws exist in the age and completeness of the data collected and in the adjusters used to take patients' severity of illness into account. Participants noted that debate about what is an acceptable level of imperfection can often derail quality measurement initiatives.

The group concluded that the cost and productivity offsets associated with technology use could not be determined systematically without widespread IT use and improvements. It also determined that the government would need to assume a key role in supporting IT development. However, until such IT capabilities are in place, incentives must be developed for providers and patients to use new high-tech procedures prudently, or health care expenditures will continue to escalate at ever-increasing speed with serious consequences for the nation's economy.

Comptroller General Presents Criteria for Evaluating Health Care Reform Proposals

Several common themes emerged from the four breakout sessions, despite their focus on different health care reform strategies. Collectively, participants' observations affirmed the position that in today's health care sector, there are few incentives for providers and consumers to be prudent in their ordering and use of health care services, too little transparency with regard to the value and costs of care, and inadequate accountability to ensure that health care plans and providers meet standards for appropriate use and quality. The groups essentially concluded that these problems cannot be solved overnight and that it will require committed, long-term resolve and a more highly evolved information infrastructure to help policymakers and the public understand the need to move beyond the status quo.

To this end, the Comptroller General has argued for adopting a systematic approach to assessing health care reform proposals. GAO therefore created a framework that includes a comprehensive set of criteria for the Congress to consider as it evaluates proposed health care reforms. GAO's framework incorporates comments made by forum participants in an extensive discussion following the Comptroller General's presentation on health care system challenges; it is constructed around the dimensions of cost, access, quality, and implementation. (See table 1.)

Table 1: Framework for Evaluating Health Care Reform

Dimension	Criterion
Cost: Does the proposal help to ensure:	•sustainable growth in public and private sector health care expenditures? For example, •are Medicare and Medicaid reform efforts aligned with the nation's long-term fiscal outlook? •are health care financing policies compatible with the efforts of U.S. companies to compete in global markets?
	•efficient production and consumption of health care resources, including •economical pricing of services? •incentives for providers to make prudent medical decisions based on benefit and cost? •consumer sensitivity to the benefits and costs of health care services?
	•that government tax incentives do not have unintended consequences?
	•that government financing meets the nation's most critical health care needs?
Access: Does the proposal help to ensure:	•guaranteed access to essential health care coverage, including •catastrophic loss protection? •children's preventive health care services?
	•an insurance market that adequately pools risk and offers alternative levels of coverage?
Quality: Does the proposal help to ensure:	•care that meets acceptable standards, including •lowering the occurrence of medical errors? •medical practices based on scientific evidence? •limiting disparities in treatment for all patients?
Implementation: Does the proposal help to ensure:	•the development of an information infrastructure that provides prompt and reliable data to monitor cost, quality, and system integrity?
	•transition to a new structure that effectively mitigates potential disruptions and any new demands on resources and affected individuals?
	•oversight and enforcement mechanisms for effective accountability?
	•reforms that consumers can easily adapt to and understand?

Source: GAO

Ideally, health care reform proposals will ultimately provide and align incentives, foster transparency, and ensure accountability. The reality is that comprehensive reforms may need to be incremental in order to minimize disruptions and facilitate political consensus. The hope is that the framework can guide us through an orderly process of debate.

Participants Share Views Through Informal Poll

At the forum's conclusion, participants were polled on 14 statements concerning the nation's health care system. A consensus on these views was neither hoped for nor expected—with the exception of the last statement asking participants for a commitment to further public dialogue on health care reform issues. The results in table 2 are based on the confidential responses of two-thirds of the participants.

Table 2: Results of the Health Care Forum Poll

	Percentages				
Statement	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
The United States has a serious and structural fiscal imbalance that requires tough choices by policymakers.	76	21	3	—	—
Patients need to be more active and informed participants in the decisionmaking process relating to discretionary and expensive medical procedures.	62	34	—	3	—
The U.S. health care system is characterized by both underuse of wellness and preventive care and overuse of high-tech procedures.	55	34	7	3	—
Defensive medicine is a significant problem that is caused by concerns about litigation.	24	38	21	17	—
The current health care system is unsustainable and requires significant reforms.	45	45	10	—	—
Ten years ago, managed care was thought to be the answer to health care cost containment, but it no longer appears to offer a long-term solution to escalating costs.	24	28	7	38	3
Based on comparisons with other major industrialized nations, it appears that the United States is lagging in the areas of cost containment, health outcomes, and access to care.	32	39	14	7	7
Given the power of providers and the desires of insured consumers, market forces alone are unlikely to reasonably constrain health care costs.	39	29	11	21	—
Health care costs represent a growing burden among employers, especially given increasing global and domestic competition.	58	28	3	7	3
Although not equally available to all segments of the population, the highest quality health care is delivered in the United States.	11	29	14	32	14
The United States pays more than its fair share of R&D for new medical products and technologies.	24	44	17	10	3
In the long run, health policies may need to focus more on attaining a basic level of health care for all Americans than on providing expanded coverage for certain segments of the U.S. population.	28	55	17	—	—
Ultimately, the division of responsibilities for health care access and financing—currently shared by the government, employers, and individuals—may need to be redefined.	18	57	14	11	—
I will continue participating in public discussions and debates that can help elevate the nation's understanding of the long-term challenges posed by today's health care financing and delivery systems.	90	10	—	—	—

Source: GAO analysis of Health Care Forum participant poll.

Note: Percentages may not add to 100 due to rounding.

Appendix I: Forum Agenda

9:00 a.m.	Welcome and Introductions *Dave Walker, Comptroller General of the United States* *Forum Participants*	
9:15 a.m.	GAO's Health Care Framework *Dave Walker, Comptroller General of the United States*	
10:15 a.m.	Break	
10:30 a.m.	Plenary Session 1: The Cost Dimension Presenter: *Uwe Reinhardt, James Madison Professor of Political Economy, Princeton University* Respondent: *Alice Rivlin, Senior Scholar, The Brookings Institution*	
11:30 a.m.	Plenary Session 2: The Value Dimension Presenter: *John Wennberg, Center for Evaluative Clinical Sciences, Dartmouth Medical School* Respondent: *Arnold Milstein, The Pacific Business Group on Health*	
12:30 p.m.	Break	
1:00 p.m.	Breakout Sessions	
	Group 1:	Consumer Cost Sensitivity Session Leader: *Paul Ginsburg, President, Center for Studying Health System Change*
	Group 2:	High-Cost Patients Session Leader: *Elizabeth McGlynn, Associate Director, RAND Health, and Director of the Center for Research on Quality in Health Care*
	Group 3:	Medical Practice Variation Session Leader: *Mark Smith, President and CEO, California Health Care Foundation*
	Group 4:	Technology Management Session Leader: *Stuart Altman, Sol C. Chaikin Professor of National Health Policy, Brandeis University*
2:30 p.m.	Break	

2:45 p.m.	Plenary Session 3: Breakout Session Conclusions *Breakout Session Leaders*
4:15 p.m.	Opinion Poll and Wrap-up *Dave Walker, Comptroller General of the United States*

Appendix II: Forum Faculty and Participants

Forum Faculty

Stuart H. Altman	Sol C. Chaikin Professor of National Health Policy, Brandeis University
Paul B. Ginsburg	President, Center for Studying Health System Change
Elizabeth A. McGlynn	Associate Director, RAND Health, and Director of the Center for Research on Quality in Health Care
Arnold Milstein	Medical Director, Pacific Business Group on Health, and National Health Care Thought Leader, Willam M. Mercer Consulting
Uwe E. Reinhardt	James Madison Professor of Political Economy, Princeton University
Alice M. Rivlin	Director and Senior Fellow, The Brookings Institution
Mark D. Smith	President and CEO, California Health Care Foundation
John E. Wennberg	Director, Center for the Evaluative Clinical Sciences, Dartmouth Medical School

Forum Participants

Janice Angell	Executive Director, Health and Benefits, 3M
Jim Bentley	Senior Vice President, Strategic Policy Planning, American Hospital Association
Barbara Blakeney	President, American Nurses Association
Charles A. Bowsher	Former Comptroller General of the United States, U.S. General Accounting Office
Karen Davis	President, The Commonwealth Fund
Senator David F. Durenberger	Chair, National Institute of Health Policy, University of St. Thomas and the University of Minnesota

Harvey V. Fineberg	President, Institute of Medicine of the National Academies
Jeffrey L. Gabardi	Senior Vice President, Policy, American Association of Health Plans/Health Insurance Association of America
Tony Gamboa	General Counsel, U.S. General Accounting Office
Mary Grealy	President, Healthcare Leadership Council
Glenn Hackbarth	Chairman, Medicare Payment Advisory Commission
Bruce H. Hamory	Executive Vice President and Chief Medical Officer, Geisinger Health System
Randy Johnson	Director, Human Resources Strategic Initiatives, Motorola, Inc.
Chip Kahn	President, Federation of American Hospitals
Vincent Kerr	Executive Vice President, Network and Clinical Solutions, UnitedHealth Group
James R. Knickman	Vice President, Research and Evaluation, The Robert Wood Johnson Foundation
Carolyn J. Luckensmeyer	President, America Speaks
Randall Lutter	Chief Economist, Food and Drug Administration, U.S. Department of Health and Human Services
Mark Miller	Executive Director, Medicare Payment Advisory Commission
Donald Palmisano	President, American Medical Association
Robert D. Reischauer	President, Urban Institute
John Rother	Director of Policy and Strategy, AARP
Dallas L. Salisbury	President and CEO, Employee Benefits Research Institute
William J. Scanlon	Director, Health Care Issues, U.S. General Accounting Office
Leon H. Schellman	Manager, United States Benefits, Procter & Gamble

Gerald M. Shea	Assistant to the President, Government Relations, American Federation of Labor and Congress of Industrial Organizations
Jean Sheil	Director of Family and Children's Programs Group, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services
Henry E. Simmons	President, National Coalition on Health Care
Pete Smith	President and CEO, Private Sector Council
Ian D. Spatz	Vice President, Public Policy, Merck and Company, Inc.
A. Bruce Steinwald	Director, Health Care, Economic and Payment Issues, U.S. General Accounting Office
Louise Van Diepen	Clinical Executive, U.S. Department of Veterans Affairs
David M. Walker	Comptroller General of the United States, U.S. General Accounting Office
Andrew Webber	President and CEO, National Business Coalition on Health

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