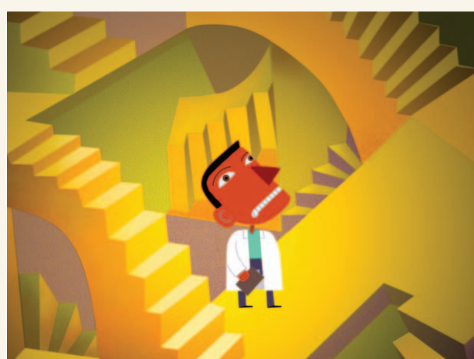
About the Roundtable

Minnesota Physician Publishing's 30th Minnesota Health Care Roundtable examined issues surrounding value in health care. Eight panelists and our moderator met on Oct. 24 to discuss this topic. The next roundtable, on April 23, will look at the medical home concept.



Defining Value in Health Care

New roles for health plans

MR. CHRISTENSON: Let's begin by defining value as to health care.

DR. GOLD: I would offer a simple definition, borrowed from the science of quality management: Value is quality divided by cost. Quality is defined as meeting or exceeding the needs of the customer. Cost is usually measured in financial terms; it could be measured in other terms. In health care, obviously, we've got more than one customer, more than one stakeholder, and cost is equally complicated. Quality divided by cost equals value. If you think about how you shop, how you decide what to buy, that definition describes your behavior.

MR. PUCCI: Value comes from technology, services, or products that prevent illness from happening in the first place, an example being vaccines, and also prevent chronic conditions and other diseases from progressing to more expensive outcomes.

DR. NICHOL: The discussion about value related to cost and quality is absolutely critical, but another element associated with this is perspective. Ultimately, we've got to be able to keep different perspectives in place at the same time we think about it within the context of the entire society.

MR. CHRISTENSON: What are the biggest reasons we have been unable to come up with a common definition of health care value?

DR. KLODAS: We have competing interests in terms of what is best for each of the stakeholders. For insurers, it may be the lowest cost and the highest profit obtained. For a patient, it may be access to the latest technology yesterday. For a physician, it may be the path of least resistance in terms of getting the patients in and out of the office. Everyone comes to the table with very different expectations and different needs. Value definitions vary according to that.

MS. BRUNNER: Another thing that really impacts the discussion about quality is our health care system. There isn't a system. It's one appendage after another. Therefore, it would be difficult to come up with a definition that would go across this "non-system" for what value is. It really depends on the lens and when your appendage was added to the system.

DR. FREDERICK: Another confusing factor is that we're not sure who the customer is—and frequently the people who are paying the bills are not considered the customer. If you're building a car, you know your customer is the person buying the car. In health care, you may have an employer group that is paying for it. You may have a patient who is consuming it. They may have misaligned incentives.

DR. GOLD: I would add a few other factors. One is a lack of knowledge. Our patients, while they're becoming more cost-sensitive to health care, frequently don't have the knowledge—we're not providing them the knowledge—to fill out the quality part. Many patients buy health care like they would buy sugar or any other commodity. To Julie's point, there is really a lot of misalignment in how the various stakeholders are incentivized to behave and the decisions they choose. Lastly, the amount of information provided consumers and the other stakeholders is grossly inadequate in terms of enabling them to make wise decisions to make the system work better.

MR. MONROE: One problem is that we tend to view health care as a commodity and not as a right. The time has come that there has to be, not only in Minnesota but nationally, a sit-down very similar to when John Kennedy said, "We're going to put a man on the moon," or Eisenhower said, "We're going to build an interstate highway system" and, lo and behold, both of those got done. The driving force in this country has to shift to quality and value because the documentation is clear: A true value-driven equation—the right procedure done at the right time and correctly—has a net long-term savings in overall cost. And we have to realize that as much as the providers need an income, the insurance companies or the nonprofits of Minnesota need a positive bottom line.

MR. KENNEDY: Another way of looking at this as opposed to defining value is to identify values. What are those values you want to see reflected in the system? We've heard several of them. Cost relates back to access. Quality is another one. Transparency. But the value that's primary to the system is the preservation of the physician-patient relationship. If all stakeholders would agree that's where the front line of health care is, that's what we have to preserve—quality, accessibility, everything needs to be reflected through that prism of maintaining and strengthening the physician-patient relationship—that would be a framework from which you could define an entire system.

MR. PUCCI: It could start with something we could all agree on, a common definition of value around prevention. Then align the activities of the health care providers and how we reimburse them accordingly. Right now we're paying physicians like they're on a hamster wheel. They're paid based on the transaction with the patient. What if we moved the resources, the same dollar and actually reimbursed them to do preventive services and counseling with patients who are driving the lion's share of cost in the system—people with cardiovascular disease, diabetes, allergy and asthma, cancer, and mental illness and depression? Those five chronic diseases are driving 75 percent of the health care dollar. If we shifted the dollars toward prevention, that move alone could turn the tide of health care dollar growth in the country.

DR. NICHOL: I'm taking a little bit different

perspective on this. I've got a 10-year-old son. Dealing with my son, I've realized that there's a 10-year-old in each of us. What do 10-year-olds want? They want immediate gratification, right? When we start talking about health care, that's pretty much the perspective we all have: We want it and we want it now. And, while our best approach would be to think about this within the prevention context, a relatively small portion of the 10-year-old population is going to be interested in that prevention approach. There are an awful lot of us who would just as soon not think about health care. We would like to access it only when we actually have to have it, and we would like that to solve our problem very, very quickly. We're going to start to see different types of plans depending upon where you fit in that continuum. If you truly have an interest in health care, you'll gravitate toward an integrated approach that incorporates the elements associated with prevention. If, on the other hand, you look at the world as an isolated set of decisions, you are going to get a product that allows you to buy six physician visits a year, you're insured against a catastrophic event of some kind, and the rest of it you're not going to care about.

MS. BRUNNER: If we could arrive at some principles or values that overarch decisions around health care, then I'm somewhat optimistic that you could make decisions that would be consistent with them. But it isn't a single value. It isn't a single principle. None of us disagree that everyone should have health care. Everyone sitting up here thinks we should have universal coverage. However, there are a couple of us who think the single-payer system is not the way to go, and there are folks who believe that is the only way to go. To talk about value, we really need to say there are a series of values in health care.

DR. KLODAS: We're in a "Cat in the Hat" moment—the mess is so big and so wide and so tall. Almost every single aspect of health care delivery is broken: The patient-physician interaction is a revolving door, bills are incomprehensible, how technology decisions are made. Physicians are paid for exactly the wrong thing: We're paid to do. We're not paid to prevent or to think, which is what our entire medical training is all about. We spend 13 years learning how to think and analyze, then spend the rest of our careers doing paperwork that we're completely unprepared to manage. We all have a sense of what value is, but to get there is so overwhelming that it would be more constructive to have realistic goals—a step-by-step approach to get to this utopia. I don't know that defining it helps us get there.

MR. CHRISTENSON: Those who support a common definition for health care value—what would you do?

DR. FREDERICK: A quick example. I was at a meeting at ICSI (Institute for Clinical Systems Improvement) regarding medical home. In a group of about 25 people, 20 were physicians, four were administrators, and one was a customer/patient. The most profound statement came when that customer spoke up and said, "I don't understand anything you're talking about." We need to have more customers figuring out what quality is and contributing to the discussion.

MR. KENNEDY: The one chair we all share no matter what role we're playing at the time is that we'll ultimately be patients. We'll ultimately be consumers of the system. So wouldn't you want to design a health care system that would provide you quality of care if you were the patient? And that takes me back to my earlier point. The one stakeholder not represented here is government, and its role is both the payer and the policy creator. Those values are across the system, but we're going to have to at some point say, "Which value is primary?" Examine it from the patient perspective, because we all ultimately will be patients or a loved one will be. That is the shared consensus we could have and the shared understanding to define the system.

MS. BRUNNER: We're completely detached from the cost of health care in this country. Patients think their health care costs $15 for a visit and $20 to get a prescription filled. We want to engage consumers in terms of having an understanding of what health care costs. We want to engage and educate them in terms of lifestyle choices. We have a huge educational opportunity here.

MR. CHRISTENSON: What does not work in defining value?

MR. MONROE: What doesn't work is a total reliance on the overall costs

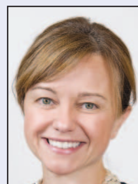
ABOUT THE PANELISTS

Julie Brunner, JD, is executive director of the Minnesota Council of Health Plans. Members provide health coverage for more than 4 million people. The council is active in community health and prevention, quality improvement, and public policy. Before joining the council in 2003, Brunner was deputy commissioner of the Minnesota Department of Health. Prior to that, she was the county administrator for St. Louis County and director of child-support enforcement for the Ramsey County attorney's office.

Bill Gold, MD, senior vice president of insights and innovations for Healthways, Inc., works with national employers to help tens of millions of people live their healthiest. He formerly was chief medical officer for Blue Cross and Blue Shield of Minnesota, where he helped launch the Center for Prevention. The center's work has led to smoke-free legislation, as well as the "do" campaign encouraging physical activity.

John P. Frederick, MD, joined PreferredOne in July 2000 and assumed the position of vice president and chief medical officer for PreferredOne entities (PPO, HMO, TPA) three months later. He has served on numerous committees, task forces, and boards of physician/clinic groups and health plans in the Twin Cities.

Brian Kennedy, JD, is a legislative affairs specialist focusing on policy questions relating to health care and elementary and secondary education. He is also executive director of the Alliance for Patient Access, a national physician network promoting pro-access health policy initiatives. Kennedy is a past executive director of the Republican Governors Association and past chairman of the Republican Party of Iowa.



Elizabeth Klodas, MD, FACC, is a cardiologist and director of cardiovascular imaging at the Center for Diagnostic Imaging, based in Minneapolis. She has written numerous scientific articles and book chapters in her field, serves on several professional committees, and is editor-in-chief of the American College of Cardiology's patient education Web site, CardioSmart.org.

Michael B. Nichol, PhD, is a professor of pharmaceutical economics and policy at the University of Southern California School of Pharmacy in Los Angeles. Before joining the USC staff in 1984, he was executive director of the Western Oregon Health Systems Agency in Eugene, Ore. Nichol's research interest focuses on observational studies within large populations.

Jim Monroe has been executive director of the Minnesota Association of Professional Employees since 1999. Prior to that, he was chief operating officer of a life and health insurance company and, before that, executive director of independent public-sector labor unions in Washington, Maine, and Ohio. Monroe has been actively involved in health care provider, access, and quality issues at the state and national level.

Michael C. Pucci is vice president of external advocacy for GlaxoSmithKline. He has also been vice president of sales for Glaxo's Cerenex Division, and then led the company's sales training department for 10 years. He represents GSK on the board of directors for Together Rx Access, a program that offers discounts to eligible people who do not have prescription drug insurance.

Robert Christenson has been involved in health care policy since 1965 and has been a health care consultant since 1978. His specialties are governance training and integrative medicine.

Bruce Silcox Photography

or the lowest costs. Any way we look at the data, we see no empirical relationship between the lowest cost and the best outcomes. Somehow we've gotten caught up in tying costs with quality or value. Health care is not a commodity. We have to look overall.

MR. PUCCI: What have we been doing for 20 years? We have been successively reducing reimbursements to the hospitals. We've reduced reimbursements to the doctors. It doesn't work. The system has to move back to the physician's responsibility to do what is right for the patient.

DR. GOLD: I take issue with the idea that cost is easy. There has been too much focus on costs that are easy to measure and not enough focus on total cost. There is an expanding appreciation of the impact of illness on productivity, both absenteeism and "presenteeism" inside organizations. Unless you consider total cost of care and the total impact of value, you're being shortsighted. The other thing Minnesota does well and should do more often is to ask the question, "Is the issue we're facing a time to collaborate or a time to compete?" Stakeholders frequently don't give collaboration an opportunity to work.

MR. CHRISTENSON: What are some differences of opinion among stakeholder groups about what should be measured, monitored, and reported in working toward a definition of value in health care?

DR. FREDERICK: Physicians would feel that the measure of quality would be that their patients survive longer; they get better care for their diabetes, etc. Patients, though, frequently are looking at a much different angle. They are saying, "How quickly can I get in to see my doctor? Why do I even have to go to my doctor—can't I get an answer over the Internet?" Until they truly get ill, they don't look at the relationship with the physician as something that has value. If we could establish a better relationship between patients and care delivery people, there would be much better interaction before the crises. Then we'll see more commonality in the definition of value.

MR. MONROE: From the employer's standpoint, it's interesting to me that we are starting to get into some of the productivity discussions. When people are sick and put off care, it does impact the outcome of the employer. But from the employer's side it's also, "What is it ultimately going to cost?" I also look at it from the perspective of the patient. We have reached the point where people are not going to the physician when they should because of how much money it costs out-of-pocket. We're witnessing declines in maintenance drugs with an aging workforce. That tells us people are doing what they should not be doing. They're postponing the medication. They are cutting pills. I've had more than a few examples within our own membership in the last six weeks of people who have ended up in the hospital or with major psychotic episodes because they changed their medication and began self-medication because they felt they couldn't afford the prescription.

DR. KLODAS: You bring up a very important point: Quality can't happen if the patient is not actively involved. As a physician, you're writing prescriptions and you're giving patients instructions on how to take care of themselves. They nod and walk out of your office and never fill the prescription. How is that quality? The quality is broken down. You can argue at which level it happened, but you know the care was not fundamentally delivered. Getting back to the cost issue, we physicians are at a breaking point. Until now we've been able to make up income and the increasing overhead we face with simply seeing more patients, putting more people through the door. Most physicians at this point are at their max. They cannot see, physically or mentally, more patients. They're done. Now, instead of sitting there thinking about ways to help our patients, we are progressively being distracted by figuring out ways to pay ourselves.

We're in a "Cat in the Hat" moment—the mess is so big and so wide and so tall.

Elizabeth Klodas, MD

DR. NICHOL: The economic situation we're facing right now is going to change the rules. The New York Times reported on Oct. 22 that, for the first time in at least a decade, we saw a drop in the use of prescriptions over the last quarter. These are, by and large, chronic medications. That is going to have some profound implications with regard to the use of other types of services that are unfortunately going to be a lot more expensive. Providers are going to have to be able to engage discussions with consumers about what they can afford. Given the fact that the provider is also talking about what the patient would prefer with regard to the way his or her health care is being provided, that is a really difficult discussion to have. We're on the cusp of a major change. The ultimate question: How can we maintain quality growth within the context of a budget constraint?

MR. CHRISTENSON: How do health plans look at this issue of what should be measured, monitored, and reported in working toward a definition of value?

MS. BRUNNER: Physicians have really stepped up to use information that is publicly reported to make changes in care delivery. Every year we're seeing improvements around measurements reported on community measurement.

DR. KLODAS: But we're not rewarded for that. When we deliver more efficient care that results in better outcomes so patients need to see us less, we get paid less. There is an implicit disincentive in the system.

DR. GOLD: I was at Blue Cross and Blue Shield when a lot of pay-for-performance programs started in Minnesota. A pretty simple concept of incentivizing physicians to change their practices and their processes toward better outcomes broke down very quickly because of how we rolled it out in Minnesota. It was an opportunity to collaborate that we didn't seize upon. The other collaboration effort—around community measurement—has been hugely successful. Minnesota is a leader in the United States.

MS. BRUNNER: Bill, I want to make your day. We just finished an agreement with the medical association where, if there is a com-

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munity measurement matrix that is agreed upon and reported, all of the plans will now notch their pay-for-performance programs to that matrix.

MR. PUCCI: I would like to focus on what the government could do. Look what you've done in Minnesota with making smoking not cool. You were a leader in the nation for banning smoking in all public buildings and restaurants and bars. The state is going to reap the benefits of that as people continue to stop smoking and the youth don't pick it up as a result of seeing their older peers doing it. The state could do the same with obesity. We're seeing a threefold increase in the rates of obesity since 1990, even here in Minnesota. Obesity drives cardiovascular disease and type 2 diabetes, which are the top two costs in the system. And 15 percent of cancers are linked to obesity, as well as mental illness and depression. So, four of the top five causes of costs in the system are linked to that. Why don't we put physical education back in school? Why don't we change the diet that's being provided to kids in school lunch programs? Why don't we work on setting examples around weight and make obesity "uncool" in society?

MS. BRUNNER: Minnesota's legislature passed a whole series of reform initiatives last year. One of the initiatives that has great potential was the state health improvement plan, which is specifically directed at reduction of obesity and tobacco use. I also co-chaired a task force for a couple of years called Steps to a Healthier Minnesota, which was the template for the state's obesity prevention plan. I commend that plan to anyone who wants to read it. It's on the state Department of Health Web site. My biggest concern about this particular initiative right now is that we're going to face a multi-billion-dollar deficit in Minnesota, and that $47 million allocation is vulnerable because it doesn't have a lot of roots yet.

MR. KENNEDY: Prevention is a matter of changing behaviors on a mass scale. When that does occur, there's also a cost factor. We raised the price of cigarettes through state taxes going up. If you look, over the last six months, at the change in behaviors with respect to driving vehicles and the decline of SUV purchases, people engaged in more energy-efficient activity. It happened because we reached a tipping point on the price of gasoline. Our consumers of health care are not payers of health care. So they have no impact of the cost of their obesity.

MR. CHRISTENSON: How can we assure all stakeholder points of view are taken into account in defining value?

MR. MONROE: We tend to start things and not look to the end. If we can say the end result is at least getting everybody to agree on common issues, understand the others, and then move forward, we've accomplished something.

DR. KLODAS: The ultimate consumer of health care is the consumer—and they are the least empowered and educated. What does it mean to go on dialysis? What is that? What are the costs? What does it feel like? How much is it going to prolong your life? To weigh those things and educate folks about every one of these types of decisions is incredibly complex, and yet it has to happen. A very simple example, but it changed the way I practice: When I was training at Mayo I saw a 75-year-old patient who had lung cancer, and it was into his esophagus. So they were going through the entire process—the x-rays, the CT scans, the specialists, the blah, blah, blah, the oncologist, the surgeon coming in and saying, "OK, we're going to take this out, and then you won't be able to eat for a while and blah, blah, blah." At the very end, I'm sitting there with him and his wife, and his wife says, "You know, doctor, Jim's never been the same since he had his gallbladder surgery. Is this much bigger than that?" Faced with the fact that the patient and his spouse really had no concept of what was being discussed, I had to sit back and say, "Let's talk about this. Let's look at what happens if we do nothing." That patient walked out of the clinic very satisfied at having decided not to have anything done. But that took a lot of education and a lot of time. If we're going to get anywhere with reining in this whole system, we have to have better-educated consumers. It's on our shoulders to be sure they are better educated.

The most important player in this discussion—the patient—is not at the table in any of the discussions that are going on.

John P. Frederick, MD

MR. CHRISTENSON: What are some technological advances that can improve the definition of value in our health care delivery system?

DR. KLODAS: The electronic medical record is the sentinel change in delivery of care that can help ensure value and quality. All of the sudden you can communicate algorithms, you can put reminders in, and you can categorize patients based on what they bring to the table and help them make better-informed decisions about their care and follow-up. That's a huge, huge change.

DR. FREDERICK: The weak link at this point is the consumer involvement and awareness. Something like the personal health record could probably have more potential for improving the dialogue between doctors and patients. In my mind, that's like the Internet for health care. It's how people start getting involved, especially the younger generation. They may well find their own best way to be able to interface with the health care system.

MR. PUCCI: The health risk assessments companies are now implementing have gone a long way toward building that bank of self-awareness about risk factors. Universally applied, along with the medical record, it will make the concept of having a medical home a viable solution.

DR. NICHOL: We've got to keep in mind there's not a lot of understanding about how we take that information and then communicate back to people in an effective way. The other part we can't lose sight of is that different people learn in different ways. Some of us are tech-oriented, and we'd love to be able to get that communication back as a message on a Blackberry or in an e-mail message. Other folks would much rather interface with someone who could sit down and explain what "medical home" is,

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Julie Brunner, JD

and really be able to help them work through some of those issues. We need to look at the electronic medical record, the personal health record, and the health risk appraisal as a foundation for a discussion.

MR. CHRISTENSON: John, what is Preferred One's perspective on the new roles it is undertaking?

DR. FREDERICK: We are doing two noteworthy things. One is to try to get more involvement from the true consumer (the patient) and make them more aware of their own health-care status. We're making sure they know what their cholesterol is and what their blood pressure is and these types of things, even to the point of encouraging the employers to give some kind of financial incentives for people who have healthier behaviors and healthier lab values. We're also trying to collaborate with provider organizations to ask how we as a health plan can give them the tools they need to be able to better deliver care and to improve the patient experience.

MR. CHRISTENSON: Bill, you were formerly with Blue Cross Blue Shield and now with Healthways. What do you see plans exploring?

DR. GOLD: There is a joke about two runners being chased by a bear. Its point is that you really don't have to outrun the bear; you just have to outrun the other runner. So often in these micro-markets, the plans are running faster than the other runner. They're maintaining their competitive edge over the other health plans and sometimes ignoring the bear, not running as fast as they could or collaborating as much as they might.

MR. CHRISTENSON: What are some new ways health plans can take leadership roles to assist patients toward positive health outcomes?

DR. FREDERICK: If we could find better ways of establishing the right incentives to do the right thing, that would go a long way. We should stretch and see how we can do things better.

MS. BRUNNER: There's some potential in the reform legislation that established baskets or bundles of care. The goal of the Minnesota legislation was to focus on total cost of care, pay the physician for the total care, and that would provide some flexibility for the physician to work at the front end as opposed to all at the deep end. I think it's going to work, though I'm having a really hard time wrapping my head around exactly how the state is going to set this up.

MR. MONROE: Medicare has run a similar trial program with some larger clinics around the country. The data shows the continuum-of-care model has resulted in savings. What Medicare did was reward the clinics a percentage of the overall savings, which flows money back into the clinics to expand their service continuum. Looking at some of these models, there is data out there that shows, both from a financial standpoint and from quality of care and quality of life, that there is a way to rethink the delivery of services. We can start some experimentation based on solid models.

MR. CHRISTENSON: What types of incentives should health plans offer doctors?

MR. PUCCI: Incentives designed purely to drive utilization of generic drugs are detrimental to health. We see a big problem with the insurance industry driving some of these plans. I like incentives that might capture the attention of the patient to get them to change their behaviors. The University of North Carolina–Chapel Hill just published a study showing incentives as small as $10 can actually move people in the positive direction. If we give people a reward—a lower premium or a lower copay or whatever you can come up with—so they see there is something in it for them, this is a wonderful idea. We reward safe drivers with lower premiums, don't we?

DR. FREDERICK: I can't let that one go on the generics. Health plans would probably be very comfortable not messing with incentives in the area of pharmacy if PhARMA did the same as far as trying to influence physician behavior.

MR. PUCCI: The pharmaceutical industry pays physicians because we are involved in the process of discovering medicines and physicians are involved in the study of medicines. We pay them to do research. We also have, in the past, paid them to do speaking for us. That is the way physicians are typically educated around products, which happens at physician forums, at state conventions, and the like. Now when the state of Minnesota, in conjunction with an advocacy group out of Washington, chose to publish that information [about pharmaceutical payments to physicians], which we have been fully disclosing for the last 10 years, there was no explanation for why those payments were made to those physicians, leaving the impression that we were actually buying the business by some mechanism or other. Where graft and corruption exist, let's expose it. It has no place in the health care system. But we have the best interests of patients in mind with what we're doing with physicians. The fact is most of our products are actually under-utilized based on the prevalence of disease in the areas we're trying to treat. Every company in any industry that makes a product has to sell and promote and advocate for its product to its user base. We're no different.

MR. CHRISTENSON: What products could be created by health plans that would

Right now we're paying physicians like they're on a hamster wheel.

Michael C. Pucci

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increase value for providers and consumers?

DR. FREDERICK: One is making it simpler for consumers to figure out who is doing the best job taking care of a diabetic or a heart patient, for example. It might be to have the health plans review the data and rate physicians and medical groups or hospitals caring for certain conditions. If we did a consumer report that says hospital A is the best place to get your bypass surgery and hospital C is the best place to get your back surgery, but here's a couple that you don't want to go to, that might help make the whole system simpler for consumers to figure out value. The conflict of interest, obviously, is in [the report's] being done by health plans. So if there could be a forum where the data we have could be used to produce outcome data for consumers, that would be a good way of doing it.

MR. CHRISTENSON: As fiscal responsibility for health care costs is increasingly transferred to individuals, what does this mean for health plans?

MS. BRUNNER: One really important problem that poses is in providing information people can access easily and understand. We have been talking about what's happening in the individual market and how challenging it is for consumers to figure out. If you go to a Web site, what does it mean? What is really covered? You have to click between different windows to try to figure out what's the network and if I pay this much, this is the coverage I have. Just deciphering that and making it easier for consumers to understand as the individual market grows is a huge challenge. It's terribly important to figure it out.

DR. GOLD: My thoughts have to do with evaluation inside health plans as these costs are shifted to individuals. The average consumer doesn't understand what that shift means until they actually experience it because copays, co-insurance, out-of-pocket are all mysterious on what you actually owe. As co-insurance or copayments go up, there are going to be other behaviors that the panel has referenced. We need to encourage health plans to measure what impact it has on cost—total cost—and on health—things like utilization of medicine, adherence, re-hospitalization—because not all patients are just going to write bigger checks without other behavior changes. And that is part of managing the population.

There has been too much focus on costs that are easy to measure and not enough focus on total cost.

Bill Gold, MD

DR. NICHOL: An example where government actually did something right was the process of implementing the Medicare Part D prescription drug coverage. Most seniors didn't have any problem going in and simply identifying the types of medications they were taking and then getting a list of plans with regard to what they covered and what the ultimate cost was going to be for the individual. One of the things the plans must do is use that as an analog to be able to say, "As you're starting to take more of the cost burden yourself, here are some alternatives to think about." Fully recognizing we don't have a commodity with regard to a physician visit as we do with drugs, at least we ought to be thinking along those lines and how we might be able to assist consumers as they make those decisions.

MR. CHRISTENSON: What problems do health plans face in balancing their proprietary business concerns with the cost transparency required for meaningful, value-based decisions across the spectrum of health care delivery?

The economic situation we're facing is going to change the rules of the game. ... Providers are going to have to be able to engage discussions with consumers about what they can afford.

Michael B. Nichol, PhD

DR. KLODAS: It's a huge challenge because a lot of the way business is done is based upon opaqueness. Negotiating rates with one physician group versus another group is all based upon one physician group not knowing what the other physician group is getting paid for the same thing. So you have different people in the system working against each other in an artificial setting. Then you have a patient who is now paying out of pocket. They're coming to the table and looking at what it costs here and what it costs there, without knowing all of the considerations that went into setting those prices. Transparency does need to happen in this very, very complex system.

DR. GOLD: Health plans would take another view—that it would be inflationary. In other words, if the contracted price per provider were exposed, the entire rate change for the network would go to the highest price. You might say that, as long as all health plans paid that, then it is no longer a competitive issue. But in their responsible role of helping to control costs where they can, they view this as a negative impact on the entire system.

MR. CHRISTENSON: Is there a fix for this in a market-based system of health care?

DR. NICHOL: Speaking as an economist, no. The analog we have here is what happened with Medicaid best-price legislation in the early 1990s, legislation that was going to provide for the lowest-cost contract. What happened was all of the pharma companies went in and said, "OK, we're going to completely rewrite all of our contracts." Floors became ceilings, and that becomes a really dangerous phenomenon. It is then inherently inflationary.

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DR. FREDERICK: The other factor here is that price is not the only issue. There is a utilization issue. We might have the lowest-priced contract for care, but you use a lot more resources. The family physician who charges $80 for an office visit and another who charges $100 are not the same if you look at the simple part. But maybe that $100 physician doesn't order the extra tests. He or she is more cautious, and uses the clinical studies to make sure they're doing the right MRI or the right CT scan, which is more cost-effective in the long run. You have to look at the whole picture of how costs are run up in our system.

MR. CHRISTENSON: What kind of new role or stakeholder group could facilitate better consumer advocacy within the health care delivery system?

DR. KLODAS: It's incumbent upon physicians to educate their patients at every single visit. But after patients leave the office and begin to search the world for information, it's incumbent upon objective organizations to help shape the way they access that information. For example, you go on the Internet to look something up, and you have no idea whether what you're looking at is credible, whether it's factual, whether it's trustworthy, whether you can actually follow that advice, whether you should get all riled up because it says, "I took this medication and my hair fell out." Having credible information is obviously very important, and certain organizations are taking on those roles. But it needs to be removed one layer from the direct interaction between patient and physician. A group may want to educate its particular patients a certain way because it benefits that group, whereas an association like the American College of Cardiology will be removed and not be as influenced.

MR. CHRISTENSON: Jim, what about labor employees?

MR. MONROE: Labor has taken a back seat in these discussions. We have really looked to cost and tried to figure out some way to resurrect the way it was in the 1940s and '50s. Labor has a lot of research capabilities that people underestimate. The model I would hate to see—AARP—is what I considered a good thing initially but has become an insurance company today. There are organizations at the national level that can come together and agree to fund and provide the resources to be supportive of organizations like Web MD but also be doing the independent research in bringing the data forward and dealing with some of the quality issues. The future role of the health insurance industry is going to have to be to provide more value to the physicians as well as the customer, resources they're not providing now. There's more multiple contracting in Minnesota than in most states. Yet I've talked to some doctors who have expressed their frustration that they negotiated one rate with X-provider, another rate with Y-provider, and another rate with Z-provider. The companies themselves have to provide the research, have to provide the resources, have to provide some of the assistance.

MR. KENNEDY: Often it is the physician who is standing there as proxy for the patient. They are the ones who are working through coverage issues, making determinations if the plan covers it, appealing adverse coverage determinations with medical directors. In the current system, that probably works best, but at the same time, from the physician's perspective, they're not being compensated for that time. It makes it increasingly difficult to really help patients secure access in that fashion.

The future role of the health insurance industry is going to have to be to provide more value to the physicians as well as the customer.

Jim Monroe

MR. CHRISTENSON: What can be done to help patients advocate for themselves?

DR. GOLD: Some would argue that, for a large number of patients, shifting more of the costs to the patients provides a greater incentive for greater advocacy. A large number of patients will become better shoppers looking for value, understanding their cost, questioning the value of a particular test, whether it can be delayed. That's going to happen. The opposite is that there will be a group who will use that cost as a way of exercising behaviors that are counter to their value. That's what we have to measure. The other thing we've talked about is much greater transparency and a better use of the data to turn it into meaningful information. So patients can learn not only about their conditions but also about the choice of providers—dispelling the notion that medical care is a commodity, it's all the same, it's a question about who's got the best parking lot, the best magazines, and the shorter wait.

MR. CHRISTENSON: What kind of new role or stakeholder group could facilitate better consumer advocacy and change? One of the things recommended in a recent IBM report was a health care "informatician"—someone who would help the consumer better navigate the health care system, provide the consumer better access to information, advocate for the consumer within the delivery system, and also assist with their financial planning for health care needs. For this to work, that "informatician" could not be associated with any existing stakeholder group.

MS. BRUNNER: I do that for my mother right now.

DR. NICHOL: The research being done now uses the term "navigator," and that's a very good descriptive term, because you're really navigating among a variety of areas. Most of the research has focused on mental health because, obviously, individuals dealing with mental health systems have got potentially reduced capacity at particular points in time. It becomes very critical that they have someone who helps them get through the process appropriately.

DR. KLODAS: It's a sad comment that we need somebody like that. The system should work so we don't have to have people explaining to us that this is a better plan for

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us. The plan itself should make it clear that this is what we need, this is the best treatment, this is the right physician, and this is the right hospital. We shouldn't have to have another layer entered into this mess.

MR. MONROE: There already is a basis starting in this country. Of the examples I know, one is run by some former insurance company execs. They have become, for lack of a better term, a "navigator" either for the employees or on an individual employer basis for doing research on necessary care. I agree it's a sad state of affairs when we have to get there but, unfortunately, we do have to get there. Things have become so confusing. Look at the highest cause of bankruptcy in this country: It was medical issues, at least until a few weeks ago, not bad financial decisions.

DR. NICHOL: The reason it's important for us to have somebody who would serve as a navigator is because the whole issue revolves around risk—our understanding of risk, our preference related to risk—and that's a very difficult concept for all of us to get our hands around.

MR. CHRISTENSON: Describe a process whereby the diverse needs in health care literacy of patients, as a stakeholder group, could be measured, aligned, and brought into a consensus-building discussion about defining value in health care.

MR. KENNEDY: Frankly, we just don't have any national leadership on these issues right now. That may change. I'm hard-pressed to believe the federal government is going to be able to do much about this, given its financial straits; but it certainly can be a leader of a dialogue.

MR. CHRISTENSON: How do we measure and align all of that diversity within the consumer group so we can have some type of discussion about defining value in health care just for the consumer, much less the larger discussion?

DR. KLODAS: You may need to take it disease-by-disease or condition-by-condition. It will be very difficult to have an overreaching discussion about value and quality because different things are important to different people, and they bring very different experiences and cultural things to the table. Maybe we're all coming back to the same thing—the importance of the patient-physician relationship, the medical home, the place you can go where somebody knows you, your history, your preferences throughout a continuum of time, rather than this very fractionated care separated by time and provider.

MR. CHRISTENSON: What new directions would you recommend to give all stakeholders an equal role in transforming health care delivery into a value-based system?

MR. PUCCI: It's no longer acceptable for us to bring a new product to market before we know whether there is going to be value and reimbursement for it. It takes 12 years and $1.2 billion to bring a new medicine to market. The effort is fraught with risk and a lot of failure. We need to start bringing in the insurance side of the business and the payers now, early on, to find out whether or not this product we're working on is actually going to be reimbursed by the system. Maybe we can engineer the product to have the attributes that make sense for the system.

The value that's primary to the system is the preservation of the physician-patient relationship. ... That would be a framework from which you could define an entire system.

Brian Kennedy, JD

DR. NICHOL: We've got to go back to that issue about evaluation. Everybody's got to be involved in the discussion around how we evaluate the impact of the care being provided. We've got to be able to identify what we really care about, what the processes are associated with it, and how we actually would measure it.

MR. KENNEDY: I take exception to the premise that all stakeholders should have an equal role. There should be a first among equals, which is the patient. We should have a patient-centric system, with the physician-patient relationship primary in that. Then we look at how all of the other stakeholders support that system.

DR. GOLD: We must work toward nailing down, from each stakeholder's view, what the aim is, what values and principles we should develop a system around, and then use that as we evaluate initiatives, projects, and investments.

MR. MONROE: I take a contrarian point of view. We have to have a national commitment—and that commitment almost has to come from the office of the president—that we are going to do something in X-number of years, and that will force people to do it. It's got to start at a high level, but it also has to involve the patient. The major issues that concern individuals about health care delivery are pretty consistent in all parts of the country. We can use those as a basis to move forward. We need to take a very aggressive step to look at how we're going to provide health care in this country in the short term and the long term—because we can't continue doing it the way we are.

DR. KLODAS: I would add cost transparency. Everybody's got to get naked in the room and say, "This is what it costs. This is how much I charge. This is how much I get reimbursed. This is how much the machine is. This is how many people I have to run through the machine to make the payment." It's very difficult to make decisions on quality and value if you don't know what the costs are. And most of the people in the system have no clue as to what the costs are.

DR. FREDERICK: The most important player in this discussion—the patient—is not at the table in any of the discussions that are going on. And instead of calling health care an entitlement, we need to make health care a responsibility. The consumers of health care have to step up and take responsibility for their own health and determining the value of the health care they're getting.

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