Getting Health Care Right

Daniel J. Hilferty

The health care debate has continued since this content was prepared for presentation in October 2017. Though some facts on the ground have changed, the author continues to advocate for transformation built on bipartisanship and innovation.

Getting health care right is the challenge of our time, the most important task before us as a society.

Over the past 8 years, the American people have seen a nearly constant struggle over how law should interact with medicine. And looming over that struggle are the most basic of ethical questions:

- Is health care a right or privilege?
- Is it acceptable for our leaders to turn health care into a political football?
- And how do we find a path forward from here?

I have been sharing my thoughts on these issues, as a CEO dealing with them every day, as well as a concerned citizen.

And frankly, it is essential that the voices of ASLME members are heard in the debate, too. Because to build a sustainable system that gives everyone access to high-quality, affordable care, we will need input from academics and industry, and from the public and private sectors alike.

Future generations are going to judge us on getting health care right. And we are not doing a very good job right now.

Health reform has been the dominant legislative debate for more than eight years. That's five congresses and two administrations dealing with these issues. Yet we have less clarity now than at any point in the process.

What is at Stake

The economic stakes are huge for America. Eighteen percent of our gross domestic product is spent on health care, heading towards 20 percent by 2025,[1] according to the Centers for Medicare and Medicaid Services (CMS).

The public health stakes are just as high. We spend far more on health care than do our economic peers around the world. We have the greatest clinicians and health systems anywhere. Yet by many measures, our outcomes lag.[2]

In the big picture, how we organize our health system will determine how effectively we respond to cri-

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ses like cancer, diabetes, opioid addiction, or even the potential of a major pandemic.

We find ourselves in a self-perpetuating crisis. If we can't fix it, people get sicker. And then they need more care. And the system becomes even more expensive.

Our window is closing to preserve the gains in access we saw under the ACA while getting control of costs. That makes this a bad time to be unable to agree even on the basic foundation of federal legislation.

But I believe a sustainable solution is still within reach. That is why we in health insurance work on this every day with our colleagues in the industry, with hospitals and physicians, with legislators and community leaders, and with our members.

Insurers have to live up to our contracts with our members and our customers. Shouldn't the government live up to the contract it made? Just living up to that contract would be a huge step in reestablishing stability.

Tenets of a Solution

I believe in the power of private sector innovation. And I want to see a health care solution that harnesses that power to transform the system.

Working with my colleagues at the independent Blue plans around the nation, we see more clearly than ever that health care is best delivered at the state and local level in collaboration with the federal government. We want a solution that preserves flexibility for local health care solutions — with federal support.

And we know that any solution must start with a bipartisan agreement to do what's best for all Americans. Health care is not a Republican or a Democratic issue. It's an American issue. Congress must come together — right, left, and center.

The Bipartisan Health Care Stabilization Act of 2017[3] sponsored by Senators Alexander and Murray, for example, aimed at the right targets: short-term affordability, increased flexibility, and the time and stability to transition to what comes next. I hope we can use it as a springboard to comprehensive solutions for the long term.

Because under our framework for getting health care right, any process must do three things:

- Stabilize a system that is very precarious right now
- Manage a productive transition to whatever the next iteration of health care reform is
- Accelerate innovations in care delivery and payment models to create true sustainability in the long run

None of that can happen without a bipartisan agreement.

Stabilization

What are the key elements of stabilizing the system? Start with the millions of newly insured Americans since the ACA.

According to the National Health Interview Survey, there were 20 million fewer uninsured in 2016 than in 2010.[4] For all the sustainability issues, that is a huge start.

If we do not have these people in the system, what does it mean? They will again show up in emergency rooms. We are on the cusp turning back the clock. We can't do that.

Short-term stability also relies on finding consensus on Cost-Sharing Reduction (CSR) payments. These critical subsidies to the consumer have been used as a political cudgel. But the ACA envisioned a long-term transition to a market-based solution that would cover more people and hopefully bend the cost curve. The CSRs were part of that transition, to bring some of the most vulnerable people into the system. And they were part of business calculations, to set premiums that a maximum number of people can afford.

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Transition

Once we have stability, we can talk about the logical transition to whatever comes next. That includes finding the balance between key tradeoffs like federal uniformity versus state flexibility, subsidies versus tax credits, and where the financial burden of reforming the system falls.

The ACA's health insurer tax was waived for one year and then reinstated. That added yet another element of instability. And this tax, aimed squarely at one stakeholder in this complicated landscape, reduces our ability to drive innovation in payment models and care delivery. Shouldn't there be a funding process that brings all stakeholders to the table? That includes providers, pharmaceutical companies, everyone.

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Whatever the next iteration of health reform looks like, there also needs to be a transition period that gives everyone time to plan and keep continuity for people who need health care. Because the victims of a chaotic transformation are not insurance companies, even though we have to figure out how to operate in an unstable terrain. They are not the legislators of one party or another trying to defend their seats. The victims are people who will lose coverage or have inadequate coverage if we cannot find a comprehensive solution with a reasonable transition period.

These issues of stabilization and transition are difficult and critical. And they only establish the baseline for long-term, sustainable reform.

Acceleration

Our ultimate goal is to accelerate the transformation of how we pay for and deliver health care in America. The key to long-term sustainability is collaboration and innovation by the private stakeholders actually on the ground in health care: insurers, doctors and hospitals, the pharmaceutical industry, device manufacturers and tech companies. We must work together, all of us, on new models to pay for and deliver care.

In the insurance industry, this is where we put our energy every day, into creating innovations that promote quality, affordability, and sustainability.

There is a broad consensus about what has to happen to create long-term sustainability: We need a system that pays for value, for outcomes, rather than for volume.

CMS put its weight behind a value-based world with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[5] And the insurance industry has made the quest for value our own. We are doing it in partnership with health care providers, which is critical. We must move into this world together.

Our company has put value-based models at the heart of our business. We combined our contracting, our health services, and our informatics into one function we call Facilitated Health Networks. We are building that function on principles of disruptive innovation.

Clayton Christenson at Harvard distilled disruptive innovation down to three principles and applied it specifically to health care in his book, *The Innovator's Prescription*.[6] To disrupt how health care is provided, you need all three principles: a new business model, backed by new uses of technology, and a new type of network called a facilitated network.

In our world, we call those elements "Engage," "Enable," and "Empower."

"Engage" is the creation of a new business model in health care payment. We are implementing that model at the most basic level: our contracts with providers.

We are working with the largest health systems in our market, places like the University of Pennsylvania Health System and Jefferson Health, to control the base rates of reimbursement.

These are conversations that other payers are having, including Medicaid. At Independence, we are seeking to develop systems, together, where we pay for outcomes, not for sheer volume: bundled payments, episodes of care, and so on. And the transition to value-based care means we share responsibility for those outcomes. We share the risk.

These outstanding health systems know the economics just like we do. It makes it much easier to move into it the value-based world when we do it side-by-side with providers. In fact, it is the only way possible.

With the University of Pennsylvania, we are raising the bar for shared risk. In April 2017, we announced a 5-year agreement. In the most significant milestone, Penn agreed to a 30-day, all-cause readmission guarantee. If a member is admitted for a diagnosis, and then within 30 days of discharge readmitted to any Penn hospital for any reason, neither the member nor the payer has to pay for that readmission.

That's not just a way of sharing the financial risk. It is an incentive for everything we want to do under Facilitated Health Networks.

The "Enable" part of our formula is technology. Health systems have electronic medical records (EMR) of patients, everything that happens at the point of care. And insurers have claims data, which are also extraordinarily powerful.

Our data tell a story of what happens to our members: every time they see a doctor, have a test, or fill a prescription. At the next level, we can link that data to demographic and financial data and get a socioeconomic picture of a patient that helps guide care.

When providers are willing to partner with us on value-based care, we can also begin exchanging data and building a database around both claims data and electronic medical records, which is the Holy Grail.

The final cornerstone of our approach is empowerment. That is how we make sure that this new value-based business model and all these data have an impact at the point of care. This means building a facilitated network, a network of networks. It means connecting the primary care provider, the specialist, the nurses, the social workers, community resources, and health systems.

And we link all these components of facilitated networks by technology. Our chief medical officer, Dr. Richard Snyder, chairs HSX, which is the health information exchange for southeastern Pennsylvania. Under a health information exchange, no matter where

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you wind up getting care, what hospital or doctor, your medical records can travel with you.

We also have a Clinical Care Transformation team, which goes out to physician practices and health systems and helps them implement the very collaborative clinical model called for by Facilitated Health Networks. Our clinicians and their clinicians are coming to the table to understand episodes of care, to figure out how we define outcomes and how we pay for them.

We have some of the most innovative American health systems in Philadelphia. And we are building a type of collaboration with them that has not been seen between insurers and providers. That is why I stay optimistic even though the legislative side of health care reform is still not settled.

If we can just get the basic foundation built and stable, then the private sector — the insurers and the health systems, all the stakeholders — has the ability to collaborate on a system that works.

Call to Action

I remain excited and committed to tackle this challenge of a lifetime. I was grateful for the opportunity to exchange ideas with passionate experts, researchers, and thinkers at the 2017 *Next Steps in Health Reform* conference organized by ASLME.

Allow me to offer a very brief call to action: We must demand of Congress that they reach a bipartisan agreement on the issues in front of them. The opinions of experts carry a lot of weight, and I hope that ASLME members will continue to add their voices.

Beyond that, I hope that this community will keep putting the focus on how health reform fits into the context of our legal system, how it affects the health of populations, how it reflects the moral compass of our nation, and how all these things are interrelated.

We must do everything we can to inspire, encourage, and support innovation. And let us continue to be partners in a great collaboration that will make our society stronger for generations.

Note

When this work was done, Mr. Hilferty was chairman of the Blue Cross Blue Shield Association, representing 36 health insurance plans nationwide; served on the executive committee of the health insurance trade association AHIP (America's Health Insurance Plans); and was a board member of BCS Financial, a company owned by the 36 Blue plans that provides financial and insurance solutions for them.

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