

Background Statement on Health Care Cost Trends and Where We Are Today
Health Care Reform Commission
December 8, 2008

Summary

Rising health care costs that exceed income and revenue growth year after year cannot be sustained indefinitely. For at least two decades, both employer-sponsored and government health insurance programs have adopted a wide range of cost containment policies aiming to moderate the persistent rise in health care spending. Overall, those past efforts have had questionable impact in curbing the long-term growth trend that is straining the entire health care system.

This statement examines the nature of the challenge and highlights what is being done in Vermont to address it.

- The unsustainable growth trend in health care costs affects every Vermonter and results in increasingly difficult choices between health care and other priorities. This is a shared problem requiring involvement of all sectors of the state in a coordinated effort to address cost pressures.
- Some options to address the cost trajectory are perceived as either not effective or not feasible, but are worthy of renewed study. First, options that do not reduce overall costs but shift them among various participants in the system are important to address fairness concerns, even if the impact on underlying cost growth is minimal. Second, further assessment is needed of options that run up against our society's reluctance to limit medical care based on cost, the impediments of federal law, and the challenges of political consensus around cost measures.
- So far, Vermont has emphasized measures that aim to reduce (not shift) costs in the health care system without impairing overall health care outcomes. These system-wide initiatives fall into four main categories:
 1. Reforming health care delivery and payment to improve prevention and management of chronic illness;
 2. Reducing the prevalence of chronic disease to minimize the number of people in need of health care services and the severity of their conditions;
 3. Streamlining administrative processes to free up providers for delivering care; and
 4. Covering uninsured Vermonters to ensure they receive timely and cost-effective primary care and chronic care.

The 60-plus initiatives that fall within those four categories are being implemented concurrently in Vermont with a level of public-private collaboration unmatched by other states.

This comprehensive reform effort will, over time, result in cost savings to the system. However, **the Commission recognizes that current measures are only a starting point and that additional measures are needed.** Some reform measures require the federal government as a partner. Even then, achieving sustainable results is not something government can do alone. It requires a commitment by all interested parties in the state to come together to evaluate and implement the most promising solutions for long term cost control and to work through the challenges and potential trade-offs that tend to divide key stakeholders and diminish political will.

Background

In its December 2007 recommendations for the 2008 legislative session,¹ the Health Care Reform Commission included the following statement:

One of the primary drivers of the state budget, and the reason that resource allocation decisions are so hard, is the impact of increasing medical costs on many sectors ranging from Medicaid to school budgets to the state's cost of health insurance for its own employees. Increasing costs of coverage have also had a major impact on private employers' budgets, and have caused a significant decline nationally in the percentage of employers who offer health insurance as a benefit. The efforts of state government to improve health insurance coverage and contain costs have come in direct response to this erosion of the availability and affordability of private coverage.

The stated legislative intent of the health reform legislation passed in Act 191 was that "all Vermonters receive affordable and appropriate health care at the appropriate time and that health care costs be contained over time." Act 191 contained the effective first steps to achieving this purpose and, in particular, found that "chronic care management is one tool to contain health care costs and ensure that the costs of Vermont's health care system become sustainable." Continued increases in health care costs at their current unsustainable rates represent the greatest single threat to successful health care reform. The Commission acknowledges that containing health care costs over time has not yet been achieved and is likely to require significant additional initiatives beyond those recommended here.

The unrelenting and unsustainable rise in health care costs has continuing urgency for the 2009 legislative session. The countercyclical nature of state budgets in the current economic downturn suggests that the demand for state health care services will increase while revenues to pay for those services decrease, aggravating the current dilemma.

The Problem of Sustainability Affects Everybody

The sustainability problem facing health care may be simply defined: The rate of growth in health care spending—driven by a combination of need, capacity, demand, and willingness to pay—exceeds the rate of growth in our ability to pay. This is an across-the-board challenge that confronts every group that shares in paying health care costs: individuals and families, employers and employees, and federal, state, and local governments.

- Each of these parties faces an annual increase in its health insurance bill arising from the same basic cost drivers—primarily advancing medical technology (including pharmaceuticals), the increasing prevalence of chronic disease in our aging population, the cultural expectations of patients and providers, and the lack of consistent and evidence-based standards of care.
- Each of these parties must find the means to pay for this annual increase in its health insurance bill.
- For each, the possible responses are identical—to somehow reduce the rate of growth in their health care spending, to increase their revenues, or to reduce their spending in other areas.

¹ http://www.leg.state.vt.us/CommissiononHealthCareReform/Recommendations_as_passed_by_HCRC_12-4-07.pdf

Furthermore, to the extent that health care spending grows faster than available revenues, the resources available to each of these parties for other essential needs will be reduced.

- For households paying out of pocket for insurance and medical care, health care spending that rises faster than household income competes with a wide range of other necessities, including food and shelter.
- For employers and employees, as health care costs rise faster than the economy as a whole, that slice of the employee compensation pie expands, at the expense of other employee benefits, employee wages, or company profits.
- For government health programs, increasing costs place enormous pressures on other parts of the budget. To illustrate, suppose total revenue grows at 4 percent per year (roughly the historical average growth in Vermont state revenues), while health care spending grows at 10 percent per year (similar to historical growth in Vermont's Medicaid program). A health program that represented 10 percent of state spending initially would grow to 50 percent of the entire budget within 30 years, eclipsing growth in available funds for other budget priorities.

As health care spending consumes an expanding share of the state's economic output, Vermonters in each of these contexts are confronted with increasingly difficult choices between health care and other priorities. This is a shared problem requiring involvement of all sectors of the state in a coordinated effort to devise and support effective solutions that broadly address cost pressures.

Solutions Must Be Effective and Feasible

The inescapable reality in attempting to slow health care spending growth is that there are no easy choices. The Commission believes that solutions proposed to control rising costs must be evaluated on at least two levels. Are they effective? Are they feasible? Many options for cost containment fall short in meeting one or both of those tests.

1. Control Costs or Shift Them? In any financing system, there are two distinct questions: how much money is needed and how should those costs be allocated (i.e., who pays)? The first question considers affordability, sustainability, and adequacy of financing at an *aggregate* level, while the second focuses more on fairness in how costs are distributed among individual participants.

A number of policy options generate cost savings for one part of the health care system, but require another part to make up for whatever is saved.

- A familiar example of cost-shifting occurs when federal (Medicare) or state (Medicaid) health insurance programs reduce reimbursement rates below the cost of providing services, leading hospitals, physicians, and other providers to "shift costs" by raising prices charged to non-government payers. (Non-government payers consist of individuals who buy insurance directly as well as a broad spectrum of employers and their employees, ranging from businesses trying to survive against global competition in a price-sensitive market to financially strapped local organizations such as schools (and their property tax payers), local governments, and non-profit organizations.)
- Similarly, when private employers or public health insurance programs (e.g., Medicaid) tighten eligibility or cut covered benefits, it shifts the cost burden of needed services onto

individuals and, when individuals cannot pay, onto the uncompensated care “safety net” (which is largely paid for by non-government payers).²

- Other examples of cost savings that shifts costs from one pocket to another happens when private employers or public health insurance programs pass on a larger share of premiums to employees; increase employees’ co-payments, deductibles and coinsurance; or encourage employees’ spouses to obtain coverage through their own employers when possible.³
- Many changes to the health insurance market also provide examples of cost shifting. For instance, the merging of markets and shifting to (or away from) community rating have no effects on total system spending or even on total health insurance spending except to the extent that previously *insured* individuals drop coverage or previously *uninsured* individuals obtain it.

Policy options that do not effectively reduce overall cost increases but shift them among various participants in the system do not provide long term solutions to underlying cost growth.

The Commission acknowledges that the cost shift resulting from reduced payments from public payers produces major distortions. Private payers contribute substantially more than they would based on their share of costs while public payers contribute less. Health insurance premiums are substantially higher than they would be if all payers reimbursed at a level nearer to costs, while the amounts paid by the state and federal governments are substantially less. Also, the expenditure of state dollars to pay down the Medicaid cost shift would draw a 60 percent federal match. For non-government payers, the cost shift raises such important questions of fairness that it makes “changing who pays” a front-burner issue, at least equal in priority to “slowing the rise in aggregate costs.” In view of this overriding fairness concern, addressing the Medicare-Medicaid cost shift is of major consequence.

At the same time, resolving the cost shift will have minimal impact at the aggregate level of health care spending. For example, suppose it would take a \$100 million increase in Medicare and Medicaid spending to reimburse private payers at cost. Ideally, this increase would enable private payers to reduce their payments by an equivalent amount, with a concurrent reduction in premiums. Yet because it is unlikely that government could absorb this increase in spending without additional revenues, the savings on the premium side would likely be offset by an increase in taxes.

Addressing the Medicaid cost shift, while a vital question of fairness, will not bend the curve of projected health care spending. It represents a one-time adjustment in who pays, but does not alter the underlying cost trajectory. To the extent that public debate remains focused primarily on “changing who pays,” we may achieve improvements in the fairness of the financing system, but we still will not have addressed the challenge of long term solutions to cost control.

² Kaiser Commission on Medicaid and the Uninsured, “Medicaid in a Declining Economy: Limited Approaches for States to Control Spending” (April 2008), <http://www.kff.org/medicaid/7769.cfm>

³ See, e.g., Center for Studying Health System Change, “Employers Shift Rising Health Care Costs to Workers: No Long-term Solution in Sight” (May 2004), <http://www.hschange.org/CONTENT/677/>

2. *Cultural, Political, or Legal Viability.* Some options that may be effective in managing health care costs run up against our society's reluctance to limit medical care based on cost, the impediments of federal law, and the challenges of political consensus around cost measures. While such options are often perceived as not feasible because of these cultural, legal, and political deterrents, they are worthy of renewed study.

a. *Cultural deterrents,* and significant political deterrents, stem chiefly from the wide gap in expectations between the health care Americans want and what the nation can afford and sustain. Prime examples include:

- *Managed Care.* Americans have high expectations when it comes to health care: we want the care we want when we want it, with little regard to cost considerations. A cultural backlash in the 1990s against tightly managed care led to a decline of strategies that limited consumer choice, such as those that confined consumers to a limited network of physicians and hospitals, controlled when consumers could seek care, and limited direct access to specialists. Managed care became more flexible and more responsive to consumer preferences, yet less able to direct people to effective care that is less costly.⁴
 - In an important new trend, employers and health plans are increasingly providing incentives for employees to opt into “high performance” networks consisting of providers who provide high value (cost effectiveness and high quality), based on growing experience that employees themselves will trade physician-hospital choice for lower costs if quality remains satisfactory.⁵
 - In addition, research showing medical technology (including prescription drugs) to be the largest cost driver suggests that applying technology more selectively to patients needs to be a central element of any long term cost containment approach.⁶
- *Targeting High-Cost, Low-Effectiveness Treatments.* Should high-cost treatments that contribute only marginally to improved health outcomes be paid for with increasingly limited health care dollars? A cost control option receiving close attention at the national level is comparative effectiveness review—“a system for generating more information about the effectiveness of medical treatments, weighing it against that of other diagnostic or treatment options, and assessing cost relative to benefits to determine whether more expensive therapies warrant their additional cost.”⁷ Proposals to assess the *cost* effectiveness of drugs, devices, diagnostic tests, and treatment procedures, along with *clinical* effectiveness, have historically met with steadfast opposition in the U.S.⁸ The fear has been that cost-effectiveness

⁴ See, e.g., Robinson, JC, “Managed Consumerism,” *Health Affairs* 24:1478-1489, 1482 (2005), <http://content.healthaffairs.org/cgi/reprint/24/6/1478>

⁵ Commonwealth Fund, “Organizing the U.S. Health Care Delivery System for High Performance” (August 2008), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=698139

Center for Studying Health System Change, “More Americans Willing to Limit Physician-Hospital Choice for Lower Medical Costs” (March 2005), <http://www.hschange.com/CONTENT/735/>

⁶ Center for Studying Health System Change, “High and Rising Health Care Costs: Demystifying U.S. Health Care Spending” (October 2008), <http://www.rwjf.org/files/research/101508.policysynthesis.costdrivers.brief.pdf>

⁷ Davis, Karen. “Slowing the Growth of Health Care Costs—Lessons from International Experience,” *NE Journal of Medicine*, 359:1751 (October 23, 2008), <http://content.nejm.org/cgi/reprint/359/17/1751.pdf>

⁸ See discussion and footnoted articles in American College of Physicians, “Information on Cost-Effectiveness: An Essential Product of a National Comparative Effectiveness Program.” *Annals of Internal Medicine* 148:12: 956-961 (June 2008), <http://www.annals.org/cgi/content/full/148/12/956#R8-8>.

information would “be used primarily for cost containment, and be a substantial step toward rationing of care.”⁹ This longstanding resistance is softening in response to the relentless escalation of costs. A leading organization for primary care physicians recently joined a growing chorus in calling for an independent national entity “to develop and disseminate evidence on comparative costs, comparative effectiveness, and cost-effectiveness in care and *to educate the public about the urgency of modifying our cultural bias toward ignoring the cost of health care*” (emphasis added).¹⁰ Should such a national entity be established, it will be years before it generates a sufficient body of work for its cost-saving potential to be realized. Furthermore, any proposal to use such information as a primary basis for making resource allocation decisions will likely face an uphill battle. For example, the main legislative proposal before Congress to create a national entity “stops short of recommending assessment of the cost-effectiveness of technologies or systematically basing insurance coverage decisions on such evidence.”¹¹ Similarly, for the past 15 years, Oregon has used clinical and cost effectiveness criteria to set priorities for health care services in its Medicaid program.¹² A recent review of Oregon’s health care priority setting initiative, and similar initiatives in seven developed nations, found that none has gained traction to the point of having significant impact in slowing the rate of spending growth.¹³

b. Legal and Practical Deterrents. A substantial limitation on Vermont’s ability to accomplish whole-system reforms designed to lower health care costs is federal law. Decisions to make across the board changes in the health care system are not entirely within the power of Vermont.

- Major changes to the state’s Medicaid program require a waiver of federal Medicaid requirements, involving extensive negotiations with federal authorities and no guarantee of success.
- Vermont has no power to modify how the Medicare program operates in the state, except by gaining a highly unusual waiver either from the responsible federal agency (Centers for Medicare and Medicaid Services) or from Congress.
- The state is constrained in its ability to influence employer-sponsored health plans (under which more than half of Vermonters are currently covered) by the federal Employee Retirement Income Security Act of 1974 (ERISA), which preempts state laws that “relate to” those plans.

c. Political Deterrents. Two considerations in particular create challenges in building political consensus around cost measures in health care:

- First, the principle of “First, do no harm” counsels caution in the face of uncertain impacts. Any changes to control costs in the health care system—whether in how we pay for health care or how we realign the delivery system—must not risk the health of Vermonters or jeopardize parts of the system that function well.

⁹ Id.

¹⁰ Id.

¹¹ Davis, Karen. “Slowing the Growth of Health Care Costs—Lessons from International Experience, *NE Journal of Medicine* 359:1751, 1753 (October 23, 2008), <http://content.nejm.org/cgi/reprint/359/17/1751.pdf>

¹² Oregon Health Services Commission, “Prioritization of Health Services for 2008-09” (June 2007), <http://www.oregon.gov/OHPPR/HSC/docs/07HSCBiennialReport.pdf>

¹³ Sabik, LM and RK Lie, “Priority Setting In Health Care: Lessons from the Experiences of Eight Countries.” *International Journal for Equity in Health* (January 2008), <http://www.equityhealthj.com/content/pdf/1475-9276-7-4.pdf>

- Second, gaining political support for cost containment initiatives often requires navigating concerns that “more cost control means less income for providers.”¹⁴ It must also address concerns about fairness and whether impacts will be distributed equitably among various stakeholders. These are challenging questions that demand careful attention. As a veteran health economist wrote recently, “[a] major reason why it is so difficult to reduce costs is that every dollar of health care spending is a dollar of income to someone involved in providing health insurance or health care.”¹⁵

Vermont’s Current Health Reform Initiatives to Lower Costs

In the realm of workable options, Vermont has emphasized measures that aim to reduce costs in the health care system without impairing health care outcomes overall. Under our current delivery system, studies have found that only about 50 percent of patients receive recommended preventive care and 60 percent receive recommended chronic care.¹⁶ Meanwhile, estimates suggest that 20-30 percent of health care spending goes for unnecessary care.¹⁷ In addition, research indicates that the U.S. spends substantially more than other industrialized countries for the same services, including prescription drugs, visits for specialty care, and a day in the hospital.¹⁸ As summed up by a leading authority on the U.S. health care system, “[r]ecent studies show that the U.S. health care system is not buying enough of the recommended care, is buying too much unnecessary care, and is paying prices that are very high, resulting in a system that costs significantly more per capita than in any other country.”¹⁹ These data provide a compelling case for the need to reengineer the health care delivery and payment system to ensure the delivery of the right care at the right time in the right place.

Vermont’s system-level cost control initiatives fall into four main categories:²⁰

1. Reengineering delivery and payment to improve prevention and management of chronic illness. As the disease burden in our population has shifted from acute illnesses (short-term, curable) to chronic illnesses (long-term, manageable), our health care system has lagged behind. Treating chronic disease is extremely costly, and the amount of care delivered and the costs associated with this care increase dramatically as chronic disease progresses.²¹ Estimates on the amount of this spending in the U.S. that is wasted on overtreatment range between 20 to 30 cents on every health care dollar spent.²² Vermont recognized early on that achieving universal health care coverage

¹⁴ Oberlander, J. “The Politics of Paying for Health Reform,” *Health Affairs* 27:544, 553-554 (October 21, 2008), <http://content.healthaffairs.org/cgi/reprint/hlthaff.27.6.w544v1>

¹⁵ Fuchs, V. “Three ‘Inconvenient Truths’ about Health Care,” *NE Journal of Medicine* 359:1749, 1750 (October 23, 2008), <http://content.nejm.org/cgi/reprint/359/17/1749.pdf>

¹⁶ National Quality Forum, “Healthcare Quality Challenges,” http://www.qualityforum.org/why_join/challenges.asp

¹⁷ Id.

¹⁸ Anderson, GE et al. “It’s The Prices, Stupid: Why the United States Is So Different from Other Countries,” *Health Affairs* 22:3 (2004), <http://content.healthaffairs.org/cgi/reprint/22/3/89>

¹⁹ Medicare Payment Advisory Commission, “Report to the Congress: Reforming the Delivery System,” (June 2008), p. 7 (*citations of the supporting studies omitted*), http://www.medpac.gov/documents/Jun08_EntireReport.pdf

²⁰ A system-wide approach to controlling health care costs must include reform of long term care and mental health care, yet cost initiatives in those areas in Vermont are beyond the Commission’s present scope of inquiry.

²¹ Wennberg, JE et al. “Dartmouth Atlas of Health Care 2008: Tracking the Care of Patients with Severe Chronic Illness” (April 2008), 1, <http://www.dartmouthatlas.org/>

²² Id. 4.

would require lower spending on medical care through effective chronic disease prevention and management. Vermont engaged a public-private partnership, known as the Blueprint for Health, to bring about fundamental reforms in the delivery of chronic care and how we pay for it. As reflected in Act 191 (2006), Act 71 (2007) and Act 203 (2008), Blueprint initiatives aim to:

- Promote a well-coordinated approach to preventing and managing chronic disease by helping primary care providers operate their practices as a patient-centered “medical home” that provides and coordinates timely and appropriate care.
- Establish local care support teams, shared across private and public payers, to assist primary care practices in coordinating community health and social services and enhancing patient self-management. These multidisciplinary teams are to include nurse educators, social workers, behavioral specialists, and community health workers.
- Create robust IT support across the entire delivery system so that all primary care practices have electronic medical record systems and are connected to a statewide health information exchange network.
- Bring about community-based reform of provider payment to reward value (rather than volume and intensity) and create meaningful incentives for providing high-value primary care with greater accountability for the quality and cost of care. Through the Blueprint, Vermont is working with major payers on payment reform specifically focused on enhancing primary care and encouraging more coordinated health care delivery.

On July 1, 2008, St. Johnsbury was the first Blueprint community to fully implement these integrated system changes across multiple providers. The second implementation site in Burlington, which began on October 1, 2008, involves a large physician practice affiliated with Fletcher Allen Health Care and a separate practice not affiliated with Fletcher Allen. The third community site in Bennington has the goal of starting in January 2009.

These are important milestones in establishing a statewide system of care that improves the lives of individuals with chronic conditions and reduces long term costs. This progress would not be possible without an enormous investment of time and resources on the part of physicians, clinical and office staff, health centers, hospitals, and others in those communities. Equally important is the leadership that the Office of Vermont Health Access (OVHA) has demonstrated in addressing chronic disease and its associated costs through its Chronic Care Programs, and the similar commitment to chronic care innovation by the state employees’ health benefits program and the state’s largest private payers, BlueCross BlueShield of Vermont, MVP Healthcare, and CIGNA.

In the coming year, the Commission will look into the feasibility of more fundamental payment reform, including designing a pilot initiative based on the “accountable care organization” model. The proposed model would span across provider types and hold providers jointly accountable for the quality of care provided and the resources used to provide it. In concept, the ACO model creates incentives for providers to change how they work with each other to coordinate care for individuals who have several chronic conditions and for those transitioning between care providers. The ACO model is being explored as an option to alleviate the adverse outcomes of

poorly coordinated care such as “patient confusion, over-treatment, duplicative service use, higher spending, and lower quality of care.”²³

2. Reducing the prevalence of chronic disease to minimize the number of people in need of health care services and the severity of their conditions.

An important precipitating factor in rising health care costs is the rapidly increasing prevalence rates of chronic illness, particularly diabetes, high cholesterol, and heart disease. Research has estimated that rising obesity rates and the growth of related chronic diseases account for more than 25 percent of national health spending increases from 1987 to 2001.²⁴ Keeping people healthier and avoiding high cost medical treatment is one of the most effective ways to reduce long-term health care costs.²⁵ A major report issued in July 2008 found that the U.S. could achieve substantial savings in health care costs with a relatively modest investment in community based programs designed to increase levels of physical activity, improve nutrition, and reduce rates of smoking and alcohol use.²⁶

Act 203 (2008) instructed the Vermont Department of Health to give priority to advancing a comprehensive strategy for reducing the prevalence of common chronic diseases through healthy lifestyles. The Department is working together with other state agencies and a diverse group of community stakeholders—including schools, worksites, health insurers, restaurants, and others. The overall objective is to influence social norms and change environments of daily living in ways that make it easier for Vermonters to engage in recommended levels of physical activity and to choose healthy foods. This approach is similar to the public health strategies operating in Vermont to reduce rates of smoking and alcohol use.

3. Streamlining administrative processes to free up providers for delivering care.

Health reform legislation has promoted efforts across all payers to reduce unnecessary health care costs by cutting through the administrative burdens inherent in our current system, thereby freeing up primary care practitioners and office staff to focus on processes of care. Examples of administrative streamlining include policies such as single credentialing of providers for all payers, common claims forms, and the use of consistent care protocols across all payers, both public and private. These initiatives challenge all payers to work together in a more consensus-driven fashion than has historically been the case.

Another area of administrative simplification is in the area of government and quasi-government regulation. Much of the health care system is subject to oversight by federal, state, and private entities, some of which is redundant. Over 25 federal agencies regulate hospitals with little

²³ Medicare Payment Advisory Commission, “Report to the Congress: Reforming the Delivery System,” Testimony of Mark E. Miller, Ph.D., before the Committee on Finance, U.S. Senate (September 16, 2008), http://www.medpac.gov/documents/20080916_Sen%20Fin_testimony%20final.pdf

²⁴ Thorpe, KE et al. “The Rise in Health Care Spending and What to Do About It,” *Health Affairs* (Nov/Dec 2005), <http://content.healthaffairs.org/cgi/content/abstract/24/6/1436>

²⁵ Partnership to Fight Chronic Disease, “Almanac on Chronic Disease: Statistics and Commentary on Chronic Disease and Prevention” (2008), 46-51, <http://www.fightchronicdisease.org/resources/index.cfm>

²⁶ Trust for America’s Health, “Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings” (July 2008), <http://healthyamericans.org/reports/prevention08/> (developed in partnership with the Urban Institute, Robert Wood Johnson Foundation, New York Academy of Medicine, California Endowment, and Prevention Institute).

coordination among them, or among similar agencies at the state and local levels.²⁷ One example is the duplicative oversight of reportable events: hospitals alone report events variously to CMS, the Joint Commission, the Department of Health, the Division of Licensing and Protection, among others, all of whom have independent investigatory authority. This is another important and complex area of administrative simplification that needs to be examined at the state and national levels.

4. Covering uninsured Vermonters to ensure they receive timely and cost-effective primary and chronic care.

Vermont's landmark health reforms have combined the expansion of health insurance coverage (Catamount Health/Green Mountain Care) with steps to make care more cost effective across the board. While covering more Vermonters increases health care spending overall, it promises to provide more cost effective care to thousands of previously uninsured residents. Substantial research has found that lack of health coverage contributes to worse health outcomes and preventable deteriorations in chronic conditions.²⁸ By improving health, the direct cost of expanding coverage is reduced, in some measure, by the potential savings to be reaped through better and more efficient use of the health care system.

Conclusion

The reform initiatives supported by the Commission are geared to reducing costs in Vermont's health care system by changing payment and delivery to keep people healthier and more effectively manage their chronic conditions when they become ill. This strategy will, over time, reduce the overall demand for health care and result in cost savings to the system. However, the Commission recognizes that these measures are only a starting point and that additional measures are needed.

There are no easy solutions to this problem, and virtually none can be accomplished by state government acting alone. The federal government has an indispensable role as a partner in creating a "high performance health system" that lowers health spending through initiatives such as payment and delivery reform, producing better health information (including comparative effectiveness information), and promoting healthy living to reduce the prevalence of chronic disease.²⁹ Most important, government alone cannot change a system whose high costs are driven in no small part by expectations that are firmly woven into the fabric of our society. To address this broadly shared problem, we need to move beyond ideological debates and come together for a productive public conversation on the most promising solutions to rising health care costs.

²⁷ American Hospital Association, "Improving the Paperwork Reduction Act for Small Businesses," Testimony of Linda Brady, M.D., before the Committee on Small Business, U.S. House of Representatives (February 28, 2008), <http://www.house.gov/smbiz/hearings/hearing-02-28-08-paperwork/testimony-02-28-08-AHA.pdf>

²⁸ See, e.g., Hadley, J. "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition," *JAMA* 297:10 (2007), <http://jama.ama-assn.org/cgi/reprint/297/10/1073?ijkey=n3EAhc0mdQ3nc&keytype=ref&siteid=amajnl>

²⁹ Commonwealth Fund Commission on a High Performance Health System, "Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending" (December 2007), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=620087

Davis, Karen. "Slowing the Growth of Health Care Costs—Lessons from International Experience," *NE Journal of Medicine* 359:1751 (October 23, 2008), <http://content.nejm.org/cgi/reprint/359/17/1751.pdf>

Vermont's private employers and health plans have pursued a wide array of measures to curtail costs. Along with Vermont's health care providers, they bring tremendous experience and expertise to address the problem. Through the public private partnership of the Blueprint for Health, these parties have come together with the state to work on shared goals to improve value in health care, which before they each might have pursued independently. All of these diverse actors coming together represents an important start in building the broad collaboration necessary to address the problem of rising health spending.

Any public conversation seeking to achieve political consensus around additional measures to control health care costs must negotiate the cultural, political, and legal barriers previously discussed that are extremely challenging. The openness to dialogue and collaboration demonstrated in Vermont's health care sector affords opportunity for our state to arrive at a realistic appraisal of the challenges, effective solutions, and potential trade-offs in a way that so far has eluded not only Vermont, but also every other state and the nation as a whole.