EVENT SUMMARY

THE ROLE OF INDEPENDENT COMMISSIONS IN CONTROLLING COSTS AND ENHANCING VALUE: INTERNATIONAL LESSONS

November 6, 2009

The Alliance for Health Reform, with support from The Commonwealth Fund, held a briefing at the Columbus Club in Union Station, Washington, DC, to examine the role of independent commissions in France, Germany, and the Netherlands involved with oversight, reimbursement, pricing, negotiation, and regulation of those countries' health systems.

Ed Howard, executive vice president at the Alliance, extended a welcome from Senators Rockefeller and Collins to those in attendance. He also thanked the panelists for their participation and The Commonwealth Fund for sponsoring the event. Mr. Howard noted that today's briefing will help elucidate how independent commissions work in improving health system performance abroad.

Co-moderator **Robin Osborn**, director of The Commonwealth Fund's International Program in Health Policy and Practice, explained that if it is our goal to achieve a high performance health system, then there are valuable lessons to be learned beyond our borders. The United States is ranked near or at the bottom of many measures of performance compared to other developed countries, she noted, including care for the chronically ill, preventative care, out-of-pocket expenditures and health information technology. Ms. Osborn noted that the speakers for this event represent systems that have demonstrated how evidence-based, transparent and politically independent bodies can foster a high performance health system.

Karl Lauterbach, director of the Institute of Health Economics and Clinical Epidemiology (IGKE) at the University of Cologne and adjunct professor at the Harvard School of Public Health, began by offering an overview of the German health system. Of the 82 million German people, 72 million are covered by statutory health insurance (SHI) (also called "sickness funds") while the rest have private insurance (usually civil servants and the upper and upper-middle classes). SHI dates back to 1883 and is now open to everyone, with payment dependent on salary but identical benefits offered to all enrollees with no surcharges based on age or risk. Public funds are used to subsidize premiums for the unemployed and for welfare recipients.

Independent organizations have been established in recent years to improve health system performance. IQWiG (Institute for Quality and Efficiency in Health Care) evaluates medical services and makes recommendations to the Federal Joint Committee (G-BA), the main decision-making body in German health care. Both began operations in 2004 (although GB-A predecessor committees date back to the 1920s). IQWiG serves as the evidence-based research body for health care decisions and is often assigned specific research questions by the German Ministry of Health and G-BA. The G-BA is tasked with making decisions regarding evidence-based coverage relating to innovations, outpatient care, hospital care; evidence-based patient information; pharmaceuticals; quality assurance; outpatient treatment;

disease management; and ambulatory care or rare diseases in hospitals. Important criteria in this decision-making process include: efficiency, cost-effectiveness and need. The Ministry of Health supervises the G-BA, which still retains strong autonomy and legal power in the health system. There is public support for these independent commissions because of their evidence-based nature, transparency and the lack of a direct government/political role, thus maintaining credibility.

The second panelist, **Cathy van Beek**, is acting chair of the executive board of the Dutch Healthcare Authority (NZa). She began by outlining the Dutch health care system, which consists of 100 percent private health insurers and 100 percent private health providers. It is a market-driven, consumer-oriented system. Health insurance is mandatory for all Dutch citizens; premiums for with the lowest incomes are subsidized through tax funds. Insurers must accept all who apply, without discrimination based on risk selection and without charging higher premiums to some based on risk. Competition between health insurance companies leads to downward pressure on costs.

The Netherlands has several major regulatory organizations. The CVZ (Health Insurance Authority) advises on the scope of basic insurance and administers the risk adjustment system, which distributes state-collected premiums to insurers based on their covered patients' relative risk. The IGZ (Healthcare Inspection Agency) sets standards and enforces quality control, and the NMa (Netherlands Competition Authority) plays a decisive role in merger control, enforces cartel prohibitions, and regulates market positions. Finally, the NZa works as an independent regulator. Key elements of supervision for the NZa include accessibility, affordability and quality. The NZA promotes effective competition and maintains close cooperation with general competition authority, the NMa. Ms. van Beek ended by offering two pieces of advice to health reformers in the U.S.: the need for an independent regulator, and the even greater need for a comprehensive system of risk adjustment.

The third panelist, **Dominique Polton**, is director of strategy and research at CNAMTS, the French National Health Insurance Fund (NHI) for salaried workers, a public compulsory health insurance covering 85 percent of the population and having extended responsibilities in the regulation of the health care system. She began by describing the French health care system: universal mandatory insurance through occupation-based sickness funds that cover 96 percent of the French population of 64 million. Delivery of care is through a mixture of public and private organizations. There is a general principle of cost sharing, but exemptions are made for low-income people facing high health care costs. Through the 2004 reform, an independent agency, the national authority for health, was created to play a significant role in oversight and decision-making. The national authority assesses drugs, devices, medical and surgical procedures, new technologies, updates the list of diseases entitled to full coverage by NHI, publishes guidelines and care protocols, coordinates the processes of accreditation, and appraises clinical practice. Additional reforms in 2009 have simplified and strengthened regional governance of the health care system by merging several existing organizations in regional health authorities (ARS).

The final panelist, **John Rother**, is executive vice president of policy and strategy for AARP. Mr. Rother noted that health reform in the U.S. could create a new Medicare commission, somewhat similar to bodies in Germany, France and the Netherlands but with far fewer

powers than the European commissions. He asked the audience consider several questions if we are to adopt a Medicare commission: 1) How broad should commission's authority be? 2) Will a commission be successful if it involves only Medicare? 3) Who should make up the commission (stakeholders or experts only)? He also reminded the group that the commission process in the U.S. will require small steps and will evolve over time. We are only at the beginning of this venture compared to our European partners, he said. Mr. Rother echoed the importance of transparency in the workings of such a commission if it is to gain public support, and the need for an evidence-based structure to gain provider support.

A lively question and answer session followed.