

Dean's Newsletter

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The State of Health in the US: Not Even the End of the Beginning

The much-anticipated decision of the US Supreme Court on June 28, 2012 reawakened the national debate on healthcare in the US with much of the rhetoric that preceded the signing into law of the Patient Protection and Affordable Care Act (ACA) by President Barack Obama on March 30, 2010. Chief Justice Roberts wrote the 5-4 decision that upheld the constitutionality of the ACA and specifically its mandate that all US citizens must have health insurance (even now nuanced through a tax or supported by the federal government if they fall below 133% of federal poverty). The “mandate” for healthcare coverage had been challenged in a series of lawsuits under the banner of the *“National Federation of Independent Business et al v. Sebelius, Secretary of Health and Human Services, et al.”* In a 59-page opinion that was joined by Justices Ginsburg, Breyer, Sotomayor and Kagan, Chief Justice Roberts concluded that an individual mandate for health insurance “is within Congress’s power to tax.” This provided an alternate way to uphold the constitutionality of the ACA, rather than the more widely and publicly debated proposal that it could be supported through the Commerce Clause that authorizes Congress to regulate interstate commerce. While Chief Justice Roberts decided against the use of the Commerce Clause, the decision that the mandate could be enforced through the taxing power of Congress proved critical to the majority decision upholding the constitutionality of the ACA.

Justices Scalia, Kennedy, Thomas and Alito filed a separate minority and dissenting opinion that the ACA “exceeds federal power” and “that the entire statute is inoperative.”

While the individual mandate was upheld by Chief Justice Roberts’ majority opinion, the Court ruled that while Congress can offer states the choice to accept an expansion of Medicaid as delineated under the ACA, they cannot do so in a fashion that the Court deemed coercive by requiring states to adopt the expansion or risk losing existing Medicaid funding. The expansion of Medicaid is thus left to the states to decide whether to pursue – a decision that has a number of implications, given the economic challenges a number of states currently face, and which have been made even worse by the economic downturn that began in 2008.

Needless to say, the issue of healthcare reform has been front and center in the press and in politics over the past several years and especially the last week. And while

the ACA is a major step toward developing a more organized health and healthcare system for the US, it is an imperfect and complicated legislation that addresses only some of the important challenges we face as a nation, where healthcare costs continue to rise and now represent nearly 18% of the GDP. These excessive costs (twice that of other developed nations) do not come with clear metrics supporting the success of our “fee-for-service” employer-based health insurance care. Nor are the issues and debates around organizing healthcare for the US new, although most efforts to reform or organize healthcare have resulted in frustration and failure – which is what makes the recent Supreme Court decision so important. Several Stanford faculty members have offered their perspectives on the Supreme Court decisions (see:

<http://scopeblog.stanford.edu/2012/06/28/stanford-experts-respond-to-supreme-courts-decision-on-health-law/>).

Indeed most of the 20th century was rife with debates about healthcare in the US, beginning with Teddy Roosevelt’s endorsement of social and health insurance during his failed attempt to regain the presidency in 1912 as the candidate from the Progressive Party. Over the ensuing decades and through nearly every presidency, from FDR through Barack Obama, decisions about whether to introduce healthcare reform were intently avoided (notably by FDR) or more comprehensively pursued (e.g., Truman, Johnson, Clinton, Obama) but virtually always with divisive forces defining the boundaries of the debate in what has become market driven healthcare rather than a more thoughtfully organized healthcare system. Even today, when the unemployment rate still exceeds 8%, many point to healthcare as one of the important drivers of the local and national economy. Certainly healthcare has become a major employer in a number of cities and states, providing jobs and opportunities for millions of citizens. However, the notion that the market will correct the rising costs of medical care has certainly not been demonstrated to date, not the least reason being that health and healthcare are not commodities in the usual sense of the word – and, in the case of the US are impacted by divergent interests and perverse incentives. As discussed in a recent Perspective article in the June 28th *New England Journal of Medicine* entitled “*The Health Care Jobs Fallacy*” (see: <http://www.nejm.org/doi/full/10.1056/NEJMp1204891>), Katherine Baicker and Amitabh Chandra argue that “*The bottom line is that employment in the health care sector should be neither a policy goal or metric of success. The key policy goals should be to achieve better health outcomes and increase overall economic productivity, so that we can all live healthier and wealthier lives.*”

The journey to healthcare reform has been detailed and documented in countless scholarly articles, policies statements, the lay and professional press and public debates. An interesting chronicle of the efforts to address healthcare by various Presidents, from FDR to Obama, is described in *The Heart of Power: Health and Politics in the Oval Office* by David Blumenthal and James Morone (2010. University of California Press). While there is no denying that the ACA is landmark legislation, it really only addresses certain aspects of health and healthcare and to varying extents is more of a reform of healthcare insurance than healthcare in its broader domains. As such it is really a beginning – but an important one nonetheless. While there are certainly many different views, had the ACA been declared unconstitutional or the mandate not allowed as a tax,

much of what has been achieved since 2010 in insurance reform would likely unravel, in part or in whole. And much of what is still to come would have been stalled or thwarted, especially in today's highly polarized political environment. Since signing the ACA by President Obama in 2010, 57 different provisions of the ACA have been brought forth, of which some 52 are in effect. These provisions are wide ranging and some are already popular to Americans; however, most are unknown, a number of which are important. Moreover, a number of important aspects and provisions of the ACA are slated for 2013-2018, several of which will play a key role in the ultimate shift from a more individualized "fee-for-service" payment system to one that is based on the health of communities and populations. These changes also take place among the most exciting eras in our understanding of human biology and the risk for disease (and health) that is both individual and population based. Brief descriptions of some of the provisions yet to be introduced are listed below.

In 2013:

- State Notification Regarding the American Health Benefit Exchange
- Closing the Medicare Part D coverage gap (sometimes referred to as the "doughnut hole")
- Establish pilot programs to develop and evaluate "bundled payments" through Medicare
- Increase matching payments for preventive services in Medicaid
- Increase Medicaid payments for primary care physicians
- Increase the threshold for itemized deductions for unreimbursed medical expenses (except for a waiver for individuals 65 years or older through 2016)
- Limit the contributions to flexible spending accounts for medical expenses to \$2500 per year
- Increase in Part A Medicare taxes on a wage basis
- Eliminate tax-deduction for employers who receive the Medicare Part D retiree subsidy payments
- An excise tax of 2.3% on the salable of taxable medical devices
- Disclosure of financial relationships between health entities – which includes physicians, pharma, etc. (previously known as the Physician Sunshine Act)
- Creation of "Consumer Operated and Oriented Plans" to foster the creation of non-profit member run health insurance companies
- Extension of the Children's Health Insurance Program (CHIP) through 2015

In 2014

- Expansion of Medicaid to individuals not eligible for Medicare with incomes up to 133% of the federal poverty level. *This was one of the provisions that was impacted by the Supreme Court decision as noted above*
- Provision that hospitals participating in Medicaid can make presumptive eligibility determinations for Medicaid-eligible populations
- The "mandate" for US citizens and legal residents to have qualifying health coverage begins to go into effect. *This was one of the central issues of the Supreme Court decision – and as noted above, it is now approved as a "tax"*

- State-based exchanges – the “American Health Benefit Exchanges and Small Business Health Options Program Exchanges” become operative for small businesses with up to 100 employees
- Health insurance premium subsidies will be available to families with incomes between 133-400% of the federal poverty level so they can purchase insurance through the Exchanges
- Guaranteed and renewable health insurance will be available regardless of health status – the ratio of which may vary by certain factors such as age, geographic area, family composition, tobacco use
- Limits on the dollar value of insurance coverage will become prohibited.
- Essential health benefits that provide a comprehensive set of services will be created and include categories of plans that can be offered
- The Office of Personnel Management will be required to contract with insurers to offer at least two multistate plans in state “Exchanges”, one of which must be by a non-profit entity and at least one of which must not provide coverage for abortions beyond those permitted by federal law
- A temporary reinsurance program will be created to collect payments from health insurers to provide payments of plans in the individual market that cover high-risk individuals
- States are permitted the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% of the federal poverty level who would otherwise be eligible to receive premium subsidies in the Exchange
- An assessment of \$2000 per full-time employees (excluding the first 30), on employers with more than 50 employees that do not offer health insurance coverage and have at least one employee who receives a premium tax credit
- Medicare Advantage plans will be required to have “medical loss ratios” no lower than 85% (which means that more dollars will go to direct health than to administrative costs)
- Financial incentives will be given to employers offering wellness programs and meeting “health-related standards”
- New fees will be levied on the health insurance sector
- An Independent Payment Advisory will be established to submit legislative proposals containing recommendations to reduce the per capita growth in Medicare spending if spending exceeds a target growth rate
- Medicare payments to Disproportionate Share Hospitals (DSH) will be reduced initially by 75% and subsequently increased on the percent of uninsured and uncompensated care provided
- Medicaid Disproportionate Share Hospital Allotments will be reduced but the methodology is to be established by the Secretary of HHS
- Medicare payments to hospitals will be reduced for “hospital-acquired conditions” by 1%

In 2015

- There will be a 23% increase in the Children’s Health Insurance Program (CHIP) match rate up to a cap of 100%

In 2016

- States are permitted to form “health care choice compacts” and insurers can sell policies in any state permitted in the compact.

In 2018

- An excise tax on insurers of employee-sponsored health insurance plans with aggregate expenses that exceed \$10,200 for individuals and \$27,500 for family coverage

Clearly the 35 additional provisions that are expected to unfold between 2013-2018 are somewhat of a hodgepodge of actions that are mainly focused on health insurance reforms and payments from federal and state entitlement programs (Medicare and Medicaid). While the ACA will provide care to a majority of the US citizens and legal residents who are currently uninsured and while it attempts to reduce some of the payments and the basis for the payments (quality and safety in addition to service performed) in Medicare and Medicaid, this does not, in itself, constitute or provide a new comprehensive healthcare system. Nor does it necessarily control healthcare costs. A short and highly readable summary of this challenge is covered well in Victor Fuch's Perspective article in the March 25, 2012 issue of the *New England Journal of Medicine* entitled “Major Trends in the U.S. Health Economy since 1950” (see: www.nejm.org/search?q=victor+fuchs). About this there is much work to be done and it will require bold and creative new approaches to the delivery of health and healthcare and a focused attention on quality, efficiency, service – and cost. Thankfully Stanford University Medical Center is deeply committed to achieving these goals and has embarked on a number of initiatives that are unfolding now and that will continuously evolve over the years ahead.

I shared above the scope of the ACA provisions yet to come since some will shape the political and healthcare debate that will unfold in the months and years ahead. I doubt that many of them will be clearly delineated in the general public coverage of the health care debate – or that those engaged in the debate fully appreciate their scope and potential impact. Clearly there will be proponents and detractors in a debate that has been unfolding for decades – and that will likely continue for decades to come. While it is easy to frame the debate around government control or escalating costs or “medical loss” and insurance or Medicare fraud and abuse, it is the human condition that underlies this issue – and it rests very much on whether we consider health care a commodity or a human right, an individual responsibility or a province for government oversight and regulation. Moreover health and healthcare cannot be divorced or separated from other societal issues and challenges. These are well framed in an article entitled “*To Isaiah*” that appeared in the June 27th issue of JAMA (see: <http://jama.jamanetwork.com/article.aspx?articleid=1199158>) that Dr. Mike Link, Professor of Pediatrics, called to my attention. Dr. Don Berwick, a longtime colleague of mine, and the recent Administrator of the Centers wrote this thoughtful essay on medicine and society for Medicare and Medicaid Services (CMS). It is very much worth reading and offers much reflection as the healthcare debate continues to unfold.

As I noted at the outset of this Newsletter, the recent Supreme Court decision is just another chapter in the end of the beginning of the healthcare reform in the US. Much remains to be done before the US has a comprehensive healthcare system we can all be proud of. Hopefully Stanford Medicine will play an important role in achieving that goal.

Team Science Workshop Series

As scientific discoveries and translations become increasingly interdisciplinary and collaborative, there is an increasing need to prepare and train scientists for effective teamwork. Since its inception in 2008 as part of the Stanford Clinical and Translational Award (CTSA), the Career Development and Diversity Center (CDD), led by Dr. Hannah Valantine, Senior Associate Dean for Diversity and Leadership, has been developing programs for education in Team Science, an emerging field focused on understanding and managing facilitators and inhibitors to interdisciplinary collaborative science.

This year, based on feedback from prior programs, the CDD created the Team Science Workshop Series, the first educational initiative with a defined curriculum on principles and strategies for team effectiveness. The series, which ran from January to May 2012, consisted of five 2.5- to 3-hour workshops led by leading scholars and practitioners in Team Science. The workshops covered, in order: 1) an overview of Team Science in the clinical and translational research landscape (Dr. Holly Falk-Krzesinski, Northwestern University Clinical and Translational Science Institute); 2) discussions on building trust, vision and expectations in scientific collaborations (Drs. Michelle Bennett and Howard Gadlin, NIH); 3) case studies of interdisciplinary clinical and translational research teams (Drs. Maritza Salazar, Claremont Graduate University, and Theresa Lant, Pace University Lubin School of Business); 4) practical exercises and discussions around management of conflicts, team norms and team processes (Dr. Barbara Gray, Penn State Smeal College of Business); and 5) interactive exercises for teamwork, trust-building and creative thinking (Dan Klein, Stanford University and Rich Cox, ImprovImpact).

A total of 41 faculty members and 10 research professionals and administrators (including three invited guests from UCSF) participated in the Team Science Workshop Series. Faculty participants were selected based on recommendations of their involvement in and commitment to interdisciplinary collaborative research. Participants represent fourteen departments in the School of Medicine, across ranks and faculty lines, and varied positions and roles in research administration. Their research teams span across clinical and basic science disciplines, often also reaching into engineering and natural sciences, and many participants hold leadership roles in multiple teams. Over half of the participants attended three or more workshops, and surveys of participants before and after the series suggest gains in feelings of preparedness for leading and building effective team processes.

Feedback from participants has been encouraging and suggestive of interest in further Team Science training programs. Participants noted the importance of gaining new perspectives and learning from one another. The series also provided networking opportunities, as some participants have joined together to begin new research

collaborations. The CDD is currently working to develop a second follow-up series to explore the practices and conditions that foster team effectiveness and productivity through more in-depth and experiential education processes.

Congratulations to Dr. Valentine and Candy Ku for a successful program, which is addressing a key training need for advancing translational research. We look forward to continuing Team Science education efforts at Stanford.

Awards and Honors

- **Dr. David Spain**, Professor of Surgery, was named the inaugural holder of the Carol and Ned Spieker Professorship at a celebratory luncheon and ceremony on June 26, 2012. This new professorship was made possible because of the generosity and commitment of Carol and Ned Spieker and also honors Ned's friend of more than six decades, Dr. David Gregg. Dr. Gregg is currently a clinical associate professor in the department of surgery and is widely recognized as an outstanding physician and surgeon who has played a critically important role in trauma surgery at Stanford – and for Mr. Spieker specifically. In addition to honoring Dr. Spain as the first incumbent of this new professorship, the Spieker family has determined that when Dr. Gregg retires, the professorship will be renamed the David L. Gregg, MD Chair in Acute Care Surgery. We are indebted to Carol and Ned Spieker and offer congratulations to Dr. Gregg and to Dr. Spain.
- **Dr. Susan Swetter**, Professor of Dermatology and Director of the Pigmented Lesion and Melanoma Program at Stanford University Medical Center and Cancer Institute was honored on May 17th with the Melanoma Research Foundation's *2012 Humanitarian Award* for her commitment to the prevention, treatment and cure of melanoma.

Appointments and Promotions

Vivien Abad has been appointed as Adjunct Clinical Assistant Professor of Psychiatry and Behavioral Sciences, effective 6/01/12.

Fred Ackroyd has been appointed as *Adjunct Clinical Professor* of Surgery, effective 9/01/12.

Kavin Desai has been appointed as Adjunct Clinical Assistant Professor of Pediatrics, effective 4/01/12.

Lorne Eltherington has been appointed as Adjunct Clinical Associate Professor of Anesthesia, effective 6/01/12.

Cia Foreman has been promoted to Adjunct Clinical Assistant Professor of Psychiatry and Behavioral Sciences, effective May 1, 2012.

Ricardo Munoz has been appointed as Adjunct Clinical Professor of Psychiatry and Behavioral Sciences, effective 9/01/12.

Rebecca Powers has been promoted to Adjunct Clinical Associate Professor of Psychiatry and Behavioral Sciences, effective 6/01/12.

Brian Roberts has been promoted to Adjunct Clinical Assistant Professor of Medicine, effective 8/01/12.

David Seidenwurm has been appointed Adjunct Clinical Associate Professor of Radiology, effective 8/01/12.

Albert Shen has been promoted to Adjunct Clinical Assistant Professor of Medicine, effective 3/01/12.

Michael Smith has been promoted to Adjunct Clinical Assistant Professor fo Psychiatry and Behavioral Sciences, effective 6/01/12.