Healthcare reform
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An update--Health Policy—and Healthcare Reform

- What is happening?
- What does it mean
  - For physicians
  - For hospitals
  - For society
  - For our children

Key Questions

- Do cost and coverage objectives reinforce or contradict each other?
- Can our current political system and leaders DO this?
- Can we get our fiscal house in order before Chinese start taking their money home?

Healthcare reform and the Physician

- This year will challenge all of us in healthcare
  - Worse recession in our memories
    - Retirement savings damaged and only half recovered
  - Face a 21% fee cut in December 250 billion
  - Political leadership is fragmented
  - “pay as you go” is back
  - Partisan politics in play
- So is healthcare too big to be fixed?

2009—Healthcare Reform---You

- Some parts of Healthcare reform and payment reform are likely
  - 46 million uninsured and another 25 million underinsured
    - Over 7 million lost their jobs since the recession—225,000 last month
    - 80 million were uninsured for part of 07-08
  - 79 million people cannot pay their medical bills
    - Over half of personal bankruptcies contribute health bills as a precipitating factor-Commonwealth Fund

—Healthcare Reform---You

- Healthcare reform and payment reform will happen-if not all this year—in the coming 3-8 years
  - 16% of the US budget is for healthcare—if it continues its present growth –in 2330 it will consume more than a third of the budget
    - We spend more on healthcare than we do on food
    - We spend more than all the Chinese do for their entire consumable goods

—Healthcare Costs

- Rate of increase -3.5% annually after adjusting for inflation
- Total costs 2.3 trillion dollars
  - CBO estimates that possibly up to a third or 700 billion is of little or questionable value
- Cost per person is $7421
- Family coverage is $12,580-doubled in 8 years
- Individual contributions are rising-$3500 per year
- Medicare costs projected to increase 100% in 10 years vs. a 60% increase in GDP

—Healthcare Reform—the Reasons for Change

- **Most expensive system in the world with little evidence of added value**
  - Data shows that in areas where there are the most specialists and highest cost-outcomes including mortality are worse
    - If a patient sees 4 doctors-medical errors are 3 times higher
  - The current wide variability in procedure use and cost is in most cases not justifiable
  - We rank 19th of industrialized countries in preventable deaths
  - We rank 29th of 37 in infant mortality
    - Twice as high as Germany and France
  - Rank 21 of 23 in child preventive health measures

Impact of Increasing Healthcare costs in the budget

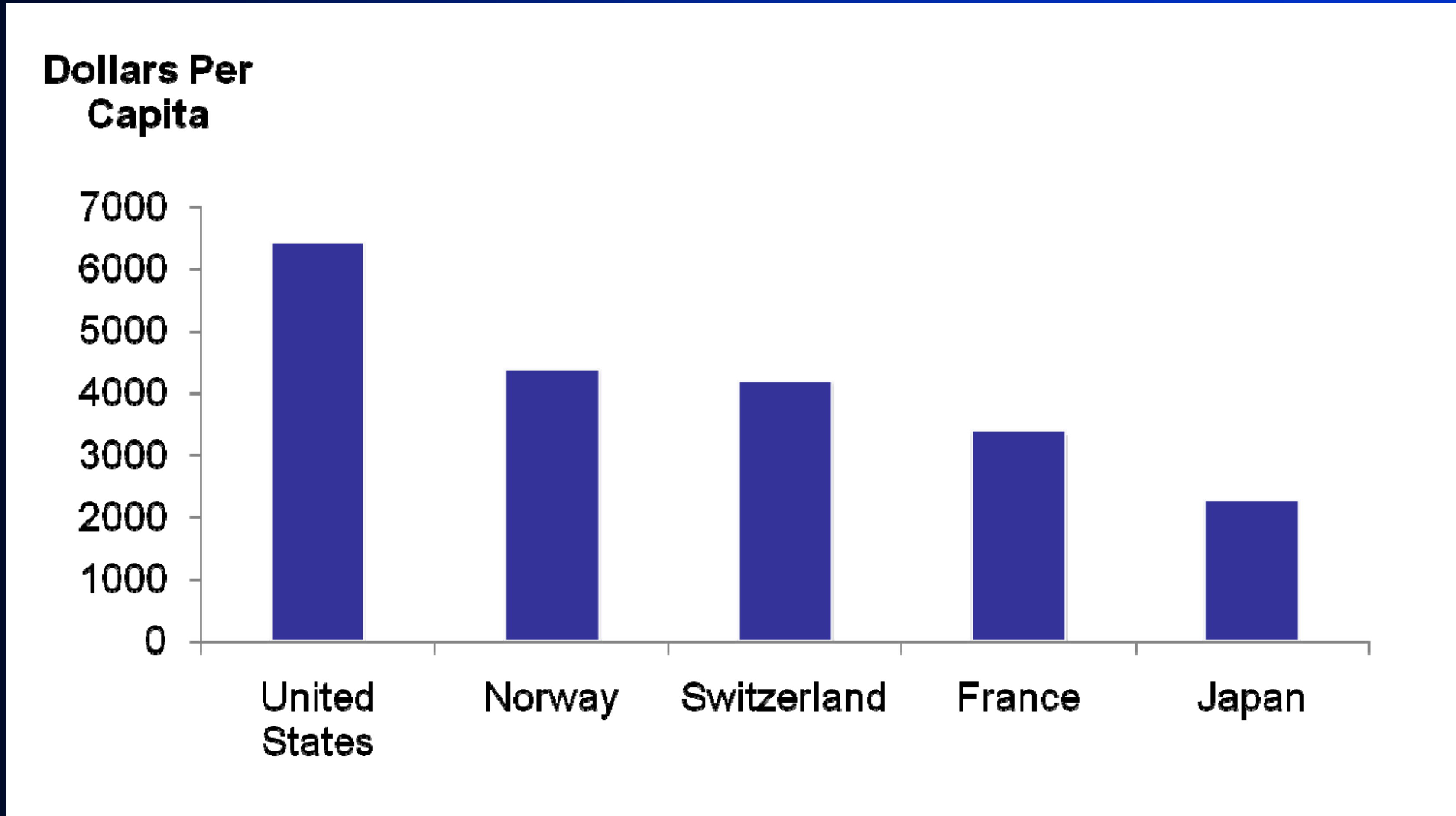
- Affecting our infrastructure
  - For schools
  - For state aid
  - For roads and bridges
  - For training and individual loans and grants
  - For R and D to build a stronger economy
  - For medical research
- Reducing peoples wages
- Reducing the number of Insured
- In 2001-2008 we created 38 million jobs-half were for healthcare-how long can this be sustained?

The Result of Increasing Healthcare Costs

Proportion with Employer provided Insurance

Companies with	2003	2004	2005	2006	2007
<220 Workers	66%	63%	59%	60%	59%
3-9 Workers	55%	52%	47%	48%	45%

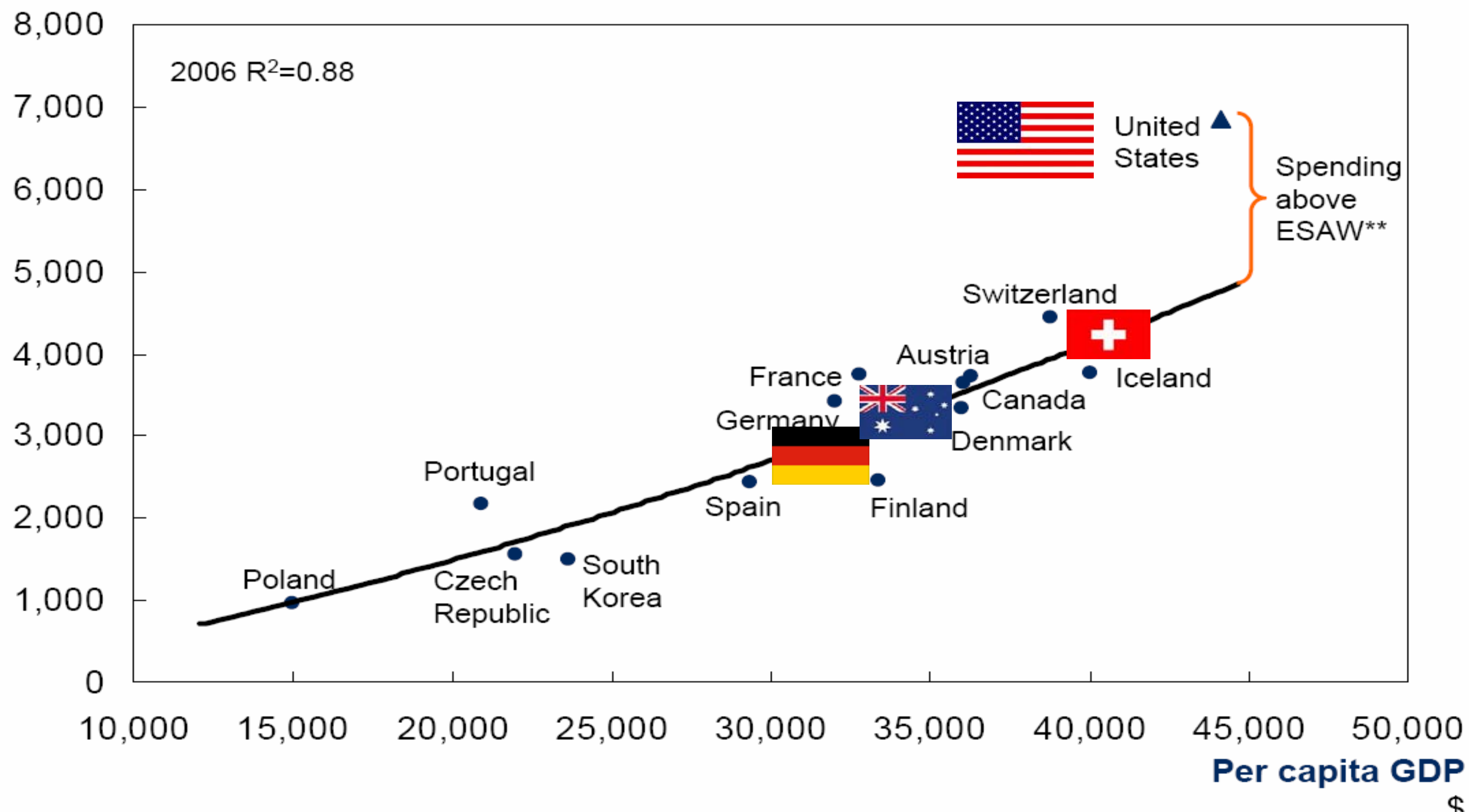
Our Health Care is Costly



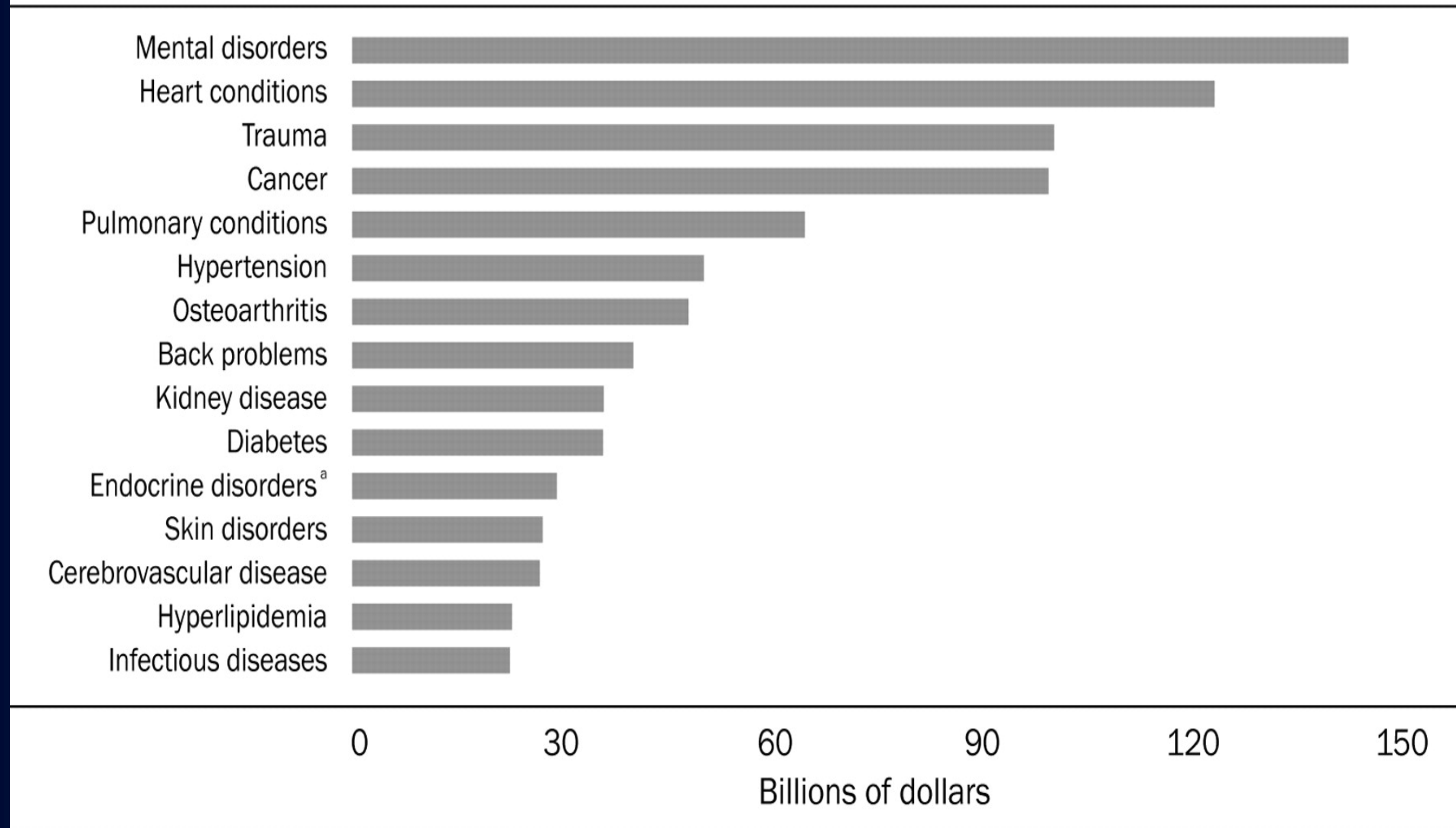
Even after adjusting for GNP—

OECD Report 2007 we are way above the expected cost vs. GNP

Cost of Healthcare per-capita vs. GNP
Why is the US so far off the line?



OECD Report 2007



Charles Roehrig, George Miller, Craig Lake, and Jenny Bryant,
National Health Spending By Medical Condition, 1996-2005,
Health Affairs, Vol 28, Issue 2, w358-367w

HEALTH AFFAIRS

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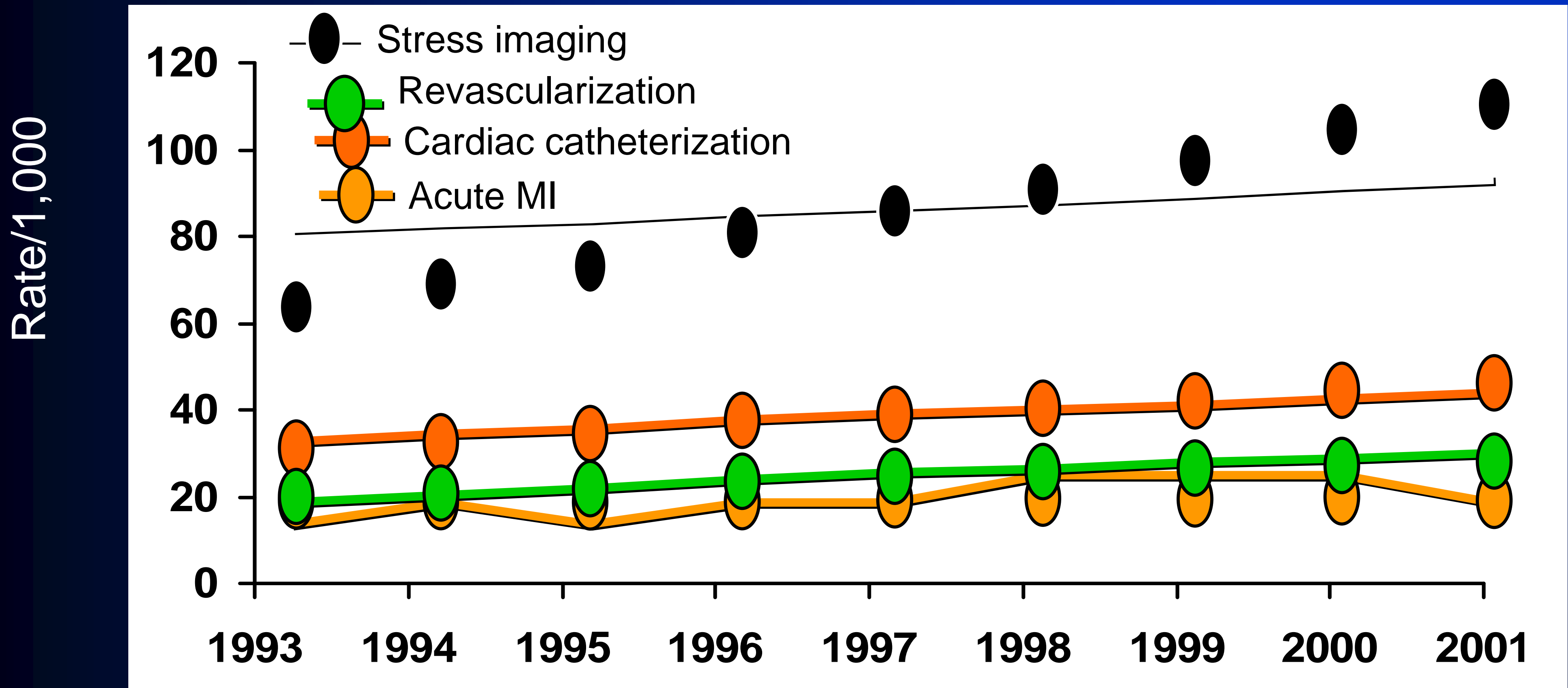
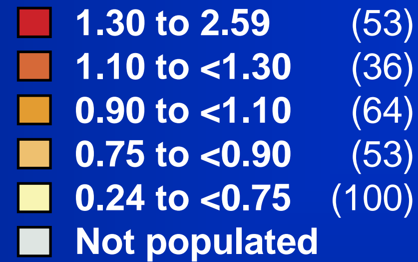
Medicare Cardiac Procedures



Lucas FL, Wennberg D. Circulation 2006;113:374-9

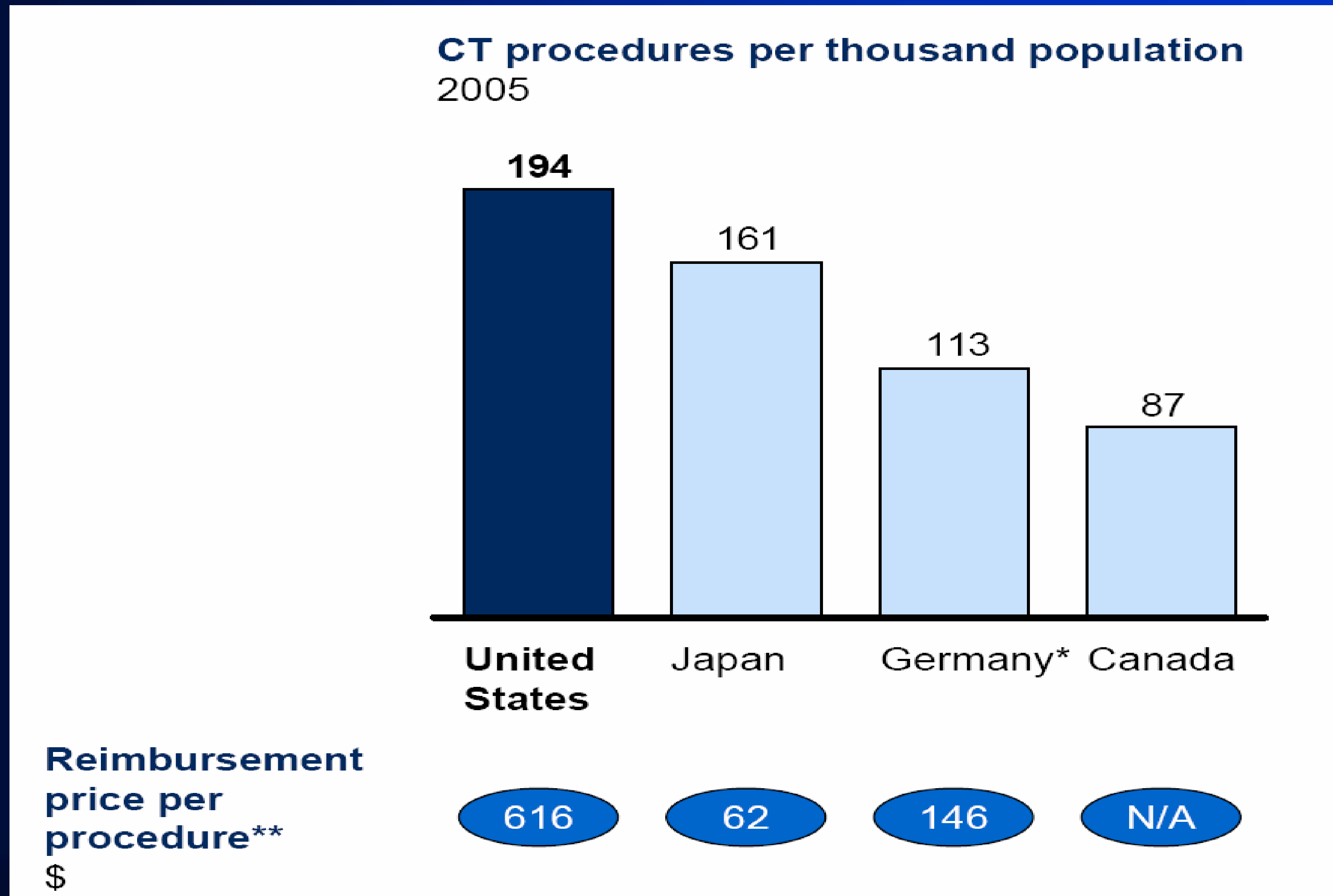
Variation in Imaging Stress Testing

Ratio of rates of imaging stress testing
to the U.S. average
by hospital referral region



Wennberg et al: The Dartmouth Atlas of Cardiovascular Health Care, 1999

Excessive (and Pricey) Inputs



McKinsey Global Institute Report, December 2008

The current incentive is Quantity vs. *Quality*

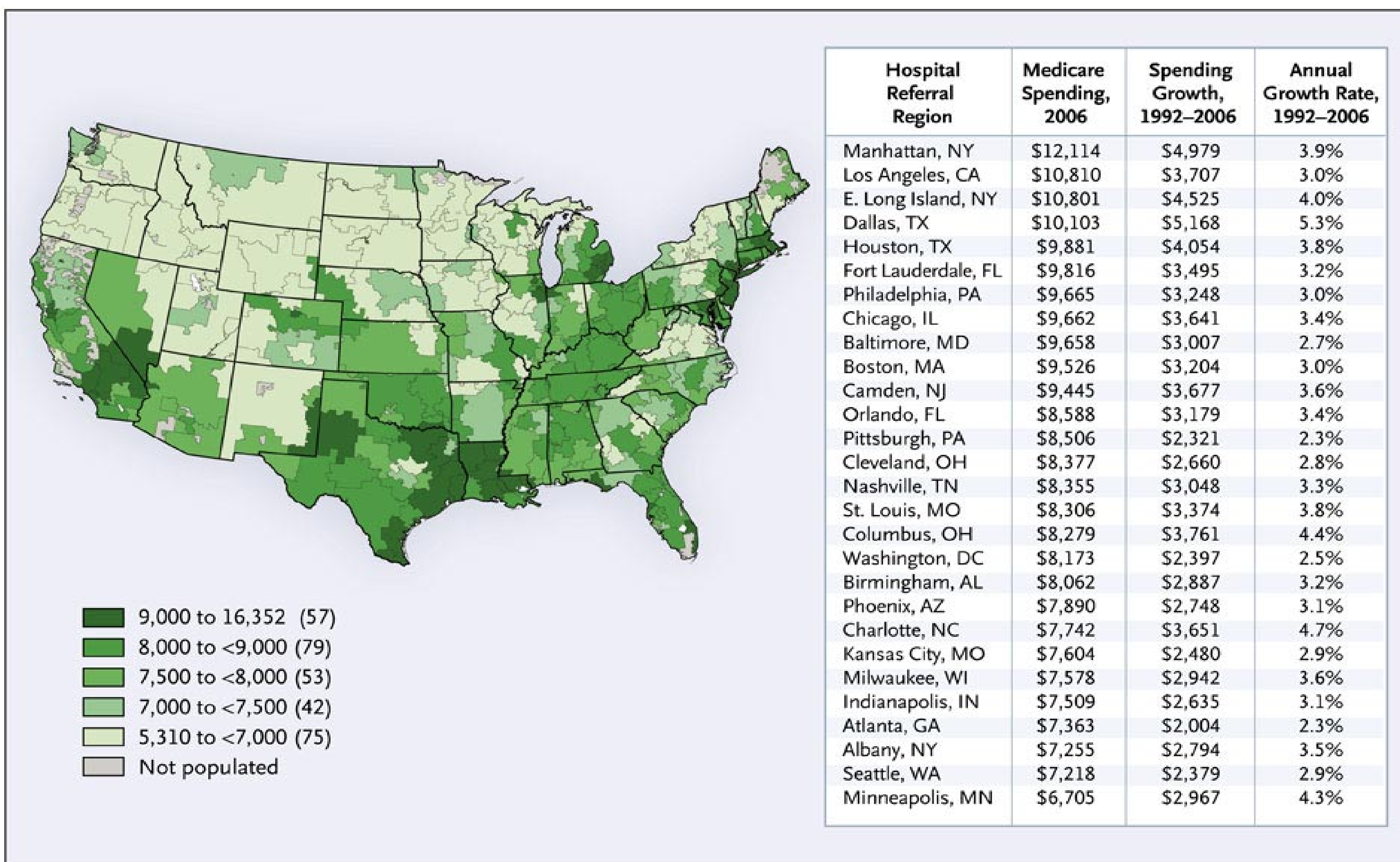
You get what you pay for

- Coronary Angioplasty—1.9 times greater than OECD
- Coronary bypass surgery—1.7 times greater than OECD
- Cardiac catheterization—1.4 times greater than OECD

These procedures by themselves are estimated
to amount to 15 billion dollars each year

- Technology is estimated to have increased cost by-38 to 65%

Growth rates for Medicare Spending



Hospital Referral Region	Medicare Spending, 2006	Spending Growth, 1992–2006	Annual Growth Rate, 1992–2006
Manhattan, NY	$12,114	$4,979	3.9%
Los Angeles, CA	$10,810	$3,707	3.0%
E. Long Island, NY	$10,801	$4,525	4.0%
Dallas, TX	$10,103	$5,168	5.3%
Houston, TX	$9,881	$4,054	3.8%
Fort Lauderdale, FL	$9,816	$3,495	3.2%
Philadelphia, PA	$9,665	$3,248	3.0%
Chicago, IL	$9,662	$3,641	3.4%
Baltimore, MD	$9,658	$3,007	2.7%
Boston, MA	$9,526	$3,204	3.0%
Camden, NJ	$9,445	$3,677	3.6%
Orlando, FL	$8,588	$3,179	3.4%
Pittsburgh, PA	$8,506	$2,321	2.3%
Cleveland, OH	$8,377	$2,660	2.8%
Nashville, TN	$8,355	$3,048	3.3%
St. Louis, MO	$8,306	$3,374	3.8%
Columbus, OH	$8,279	$3,761	4.4%
Washington, DC	$8,173	$2,397	2.5%
Birmingham, AL	$8,062	$2,887	3.2%
Phoenix, AZ	$7,890	$2,748	3.1%
Charlotte, NC	$7,742	$3,651	4.7%
Kansas City, MO	$7,604	$2,480	2.9%
Milwaukee, WI	$7,578	$2,942	3.6%
Indianapolis, IN	$7,509	$2,635	3.1%
Atlanta, GA	$7,363	$2,004	2.3%
Albany, NY	$7,255	$2,794	3.5%
Seattle, WA	$7,218	$2,379	2.9%
Minneapolis, MN	$6,705	$2,967	4.3%

Fisher et al, NEJM 2009; 360:849

Geographic Variation

- There is a 4 fold difference in hospital care intensity among 306 hospital referral regions
  - Newark, Miami, LA 80-90% higher than average
  - Chicago, New Orleans and Philadelphia 45% higher
  - Cleveland, St Louis, , Dallas and DC are average
  - Minneapolis, Seattle, Denver 25-35% lower
- During their last 2 years of life, patients in LA spent 28 days in the hospital and had 76 different physician visits vs. 12 days and 12 visits in Portland –and there was an inverse relationship for intensity and patient satisfaction as well as for quality measure performance

Wennberg, Health Affairs:2009; 28:103

What does higher spending buy?

More discretionary "supply-sensitive" services

	Rate of Avoidable Admissions[1]	Physician Visits[2]	Per-beneficiary spending on imaging	Ratio Primary Care to Specialist visits[2]	Percent seeing 10 or more MDs[2]
Miami	95	106	$1434	0.72	51
E. Long Island	75	91	$1388	0.97	50
Boston	81	59	$864	1.20	39
San Francisco	52	64	$687	1.12	32
Salem	44	38	$512	1.30	18

Notes

1. Ambulatory Care Sensitive Hospitalizations per 1000 Medicare beneficiaries
2. Utilization during last 2 years of life, Medicare beneficiaries with serious chronic illness.

And more isn't better

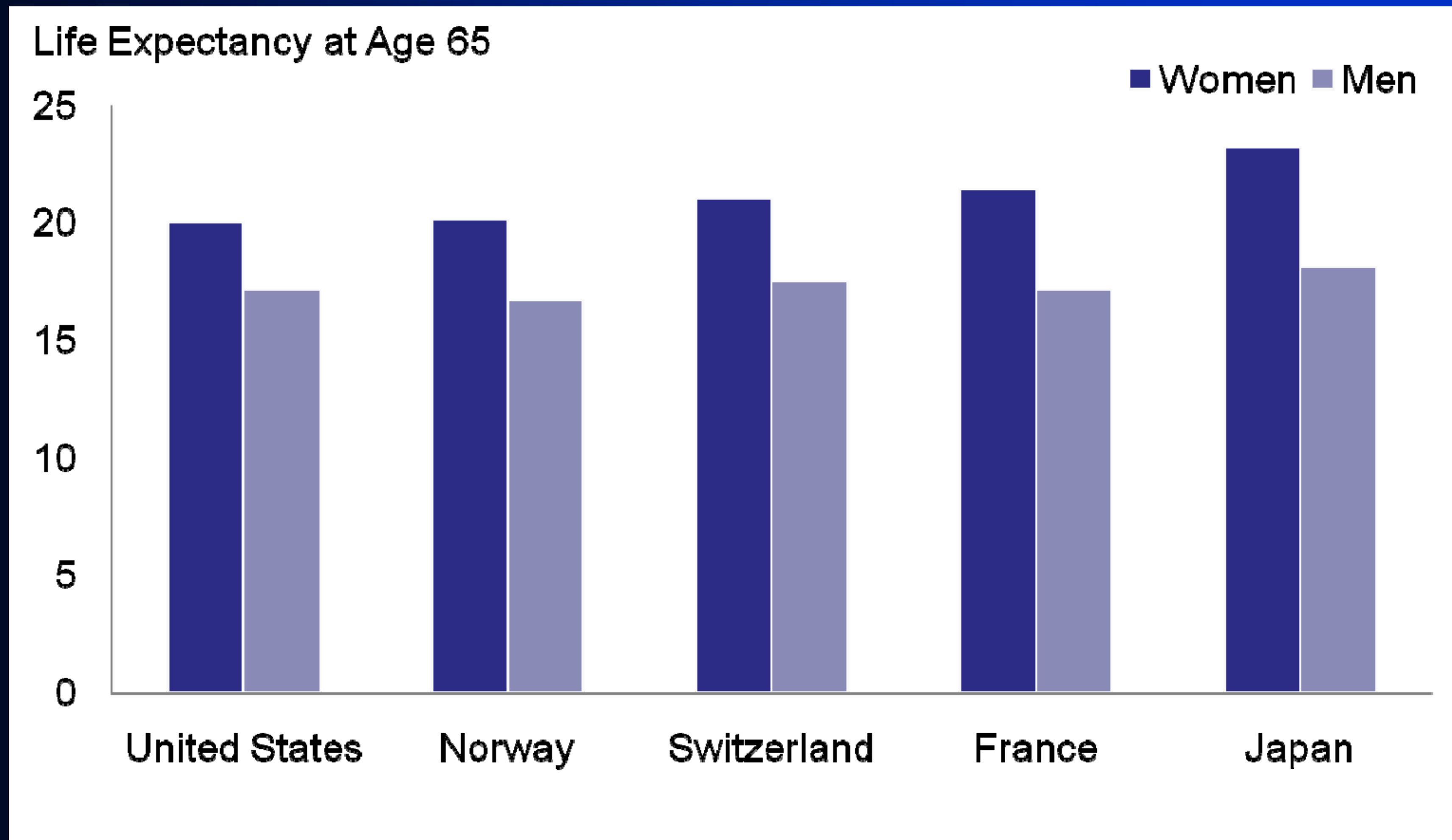
(1) Fisher et al. Ann Intern Med: 2003; 138: 273-298
(2) Baicker et al. Health Affairs web exclusives, October 7, 2004
(3) Fisher et al. Health Affairs, web exclusives, Nov 16, 2005
(4) Skinner et al. Health Affairs web exclusives, Feb 7, 2006
(5) Sirovich et al Ann Intern Med: 2006; 144: 641-649
(6) Fowler et al. JAMA: 299: 2406-2412

The Facts about Variation in Growth

- Using 2008 data-by 2023 at a 3.5% (inflation adjusted) annual increase in rate-Medicare would be $660 billion in the red
- If the per capita rate was reduced by a third—2.4%(same as San Francisco)—Medicare would be $758 billion in the black
  - *a $1.72 trillion difference*

Fisher et al, NEJM 2009; 360:849

Value of the extra spending is Questioned



OECD Report 2007

So what is the variation due to?

- Not explained fully by
  - Population health
  - Availability of technology
  - Capitation
  - Different rates of diffusion of evidence based treatments
  - Doctors denying needed care
  - Differences in payer mix
- But is explained by how physicians and others respond to the availability of technology, capital and other resources in a FFS payment system

Fisher et al, NEJM 2009; 360:849

The current payment system

- Does not reward physicians for taking the time to explain why a test or procedure may not be necessary
  - The system incentivises procedures and testing-it does not reward “evaluation and management”
- Hospitals lose money if they reduce readmissions-their margins avg. only 2-4%
  - They lose market share if they don’t compete in the medical arms race-no rewards for collaboration or coordination

President's Original Principles for HCR

- Protect the Financial Health of families
  - *Reduce premiums, reduce bankruptcies*
- *Make coverage affordable*
  - *Reduce administrative costs and unnecessary tests*
- *Aim for Universal coverage*
- *Provide portability of coverage*
  - *An insurance exchange*
- *Guarantee choice of provider*

President's Original Principles for HCR

- Invest in Prevention and Wellness
  - *Get in shape*
  - *Individual responsibilities*
- *Improve Quality*
  - *Payment system is backwards*
- *Maintain long-term fiscal sustainability*
  - *Taxes*
  - *Increased system efficiency to pay part of the way*

ACC Public Opinion Survey Results

- **It's about the quality, not the volume.**
  - Americans believe that quality of care is the fairest way to compensate doctors.
  - 64% percent state that quality of care and only 2% states that "volume" should determine physician payment
  - 83% wanted the ACC to advocate a new standard that focuses on **quality** and **cost-efficient care**.

QualityFirst

AMERICAN COLLEGE of CARDIOLOGY

The Potential Power of Health IT

Pilot: Effect of Point-of Care decision support for CT Procedures

CT Scans

15000
12500
10000
7500
5000
2500
0

2000_4 2001_1 2001_2 2001_3 2001_4 2002_1 2002_2 2002_3 2002_4 2003_1 2003_2 2003_3 2003_4 2004_1 2004_2 2004_3 2004_4 2005_1 2005_2 2005_3 2005_4 2006_1 2006_2 2006_3 2006_4 2007_1 2007_2 2007_3 2007_4

Decision Support Rules In Effect

CT growth went from 12%/yr to 1%

Shishrom et al Radiology; 251; 2009

QualityFirst

What Ideas are in play to get the Savings

- Bundling 30 day post admission care
  - *18% of Medicare patients are readmitted within 30 d*
- *Extend pay for quality*
  - *Reward MOC-punish those that do not*
- *Bonus eligible organizations-ACOs (capitation-chapter 2)*
- *Penalize overutilization-5% for top 10%*
- *Increase primary care reimbursement by 5%-Robin Hood method*
- *Eliminate specialty hospitals*
- *Comparative effectiveness studies*
- *Revise the anti-trust laws*

Where do the Dollars Go?

The Targets

- Hospitals 696 billion
- Physicians and clinical services 479 billion
- Pharma 228 billion
- Government and Private Insurance Overhead 156 billion

Where are we?

- Senate HELP Committee
  - Insures 16 million more-up to 400% of the poverty level
  - Cost 1.3 trillion
  - Includes a public plan
- Senate Finance
  - *Hoping for bipartisan support*
  - *829 billion*
  - *Reduces the deficit by 81 billion*
  - *Insures another 29 million*
- *The Tri-committee house bill*
  - *Insures almost everyone*
  - *Includes a public plan*
  - *Cost 1.2 trillion*

Tripartite House Bill -Specifics

- Rebases SGR
  - 2% increase for Primary care
  - 1% increase for specialists
  - Bonus amounts for ACOs
- Provides for Insurance exchanges-small businesses of 20 workers or less
- Taxes high wage earners-350K-1%
- Individual mandate-2.5% penalty if not insured
- Requires employer coverage-2-8% penalty if not
- 5% Bonus to Primary care
- Continued Graduate medical education Support
- Pays a little for quality

Some Senate Finance Bill Specifics

- Small business tax credits-25 or fewer and wages less than 40k
- 50% discount for all brand name drugs
- Provides for Insurance exchanges-comparison of benefits across plans
- Transparency—
  - Insurers-everything not spent on healthcare
  - Hospitals-standard charges for all services
- Insurance
  - Interstate sale of insurance permitted
  - State based insurance exchanges
  - Benefits-bronze, silver, gold, platinum and invincible options
  - Annual and lifetime limits on liability
- Healthcare affordability tax credits up to 400% of poverty level
- In 2013-required to have insurance or increasing penalties up to $1200
- Employers with more than 50 employees pay a fee if they do not offer insurance
- Funding for consumer COOPs to form insurance companies
- Medicaid up to 133% of poverty level

More Senate Finance Bill Specifics

- New standards for the treatment of patients with disabilities
- Prevention and risk assessment covered every other year
- Incentives for healthy lifestyles
- Hospital value based purchasing-payment for cardiac, surgical and pneumonia quality indicators
  - Penalty if a hospital with high rate of acquired infections
  - Readmissions-in 2011 payment reduced 20% if rehospitalized within 7 days, 10% if within15 days
- Physician value based purchasing-
  - all must participate by 2011
  - incentives to order Appropriate high cost imaging
  - penalizing high utilizers
  - more Medicare feedback on performance
- Quality reporting and payment for chronic care facilities

More Senate Bill Specifics

- CMS innovation center-authority to test new provider payment models
- Taxes to insurers, pharma, and devices
- Primary care and general surgery bonus of 10%-paid in half by 0.5 reduction in other expenses
- SGR up 0.5%-1 year only
- Medicare Commission to adjust provider payments rates to be appropriate
- Transparency of physician and hospital RWI with any payment; sample drugs reported to the Secretary
- A failsafe reduction in the payments if the annual budget projected to increase the deficit

What has to happen?

- The Senate HELP and Finance Bills have to be reconciled before a bill can come to the floor
- The House and Senate committees must then reconcile differences in each bill before a single bill can be brought before both bodies

Greatest Concern

- More insured but minimal health care reform will lead to…….
  - Doctors and hospitals picking up a big portion of the tab.
  - Remember—CMS will adhere to their budget-and if they are not empowered to experiment with real delivery reform-they will simply price cut

- Also-remember the President's words—if the costs exceed the budget, the Secretary will have the authority to rein in costs

November 2009Concerns for Cardiology

- Initiating the proposed practice expense survey data will cut cardiology by 11%

TABLE 39: CY 2010 Total Allowed Charge Impact for Work, Practice Expense, and Malpractice Changes*

	(A) Specialty	(B) Allowed Charges (mil)	Impact of Work RVU Changes	(C) Impact of PE RVU Changes**	(D) Impact of MP RVU Changes	(E) Combined Impact
1	TOTAL	$ 77,744	0%	1%	0%	1%
2	ALLERGY/IMMUNOLOGY	$ 171	0%	0%	-2%	-3%
3	ANESTHESIOLOGY	$ 1,713	0%	5%	1%	6%
4	CARDIAC SURGERY	$ 371	-1%	-1%	3%	-2%
5	CARDIOLOGY	$ 7,179	0%	-10%	-1%	-11%
6	COLON AND RECTAL SURGERY	$ 129	-1%	5%	1%	5%
7	CRITICAL CARE	$ 221	0%	3%	1%	3%
8	DERMATOLOGY	$ 2,504	0%	2%	0%	3%
9	EMERGENCY MEDICINE	$ 2,395	0%	2%	0%	2%
10	ENDOCRINOLOGY	$ 370	-1%	3%	0%	3%
11	FAMILY PRACTICE	$ 5,055	2%	5%	1%	8%
12	GASTROENTEROLOGY	$ 1,779	-1%	1%	0%	0%
13	GENERAL PRACTICE	$ 719	1%	5%	0%	6%
14	GENERAL SURGERY	$ 2,213	-1%	4%	1%	4%
15	GERIATRICS	$ 167	1%	6%	1%	8%
16	HAND SURGERY	$ 89	-1%	4%	0%	3%

What will be the future trend?

- Physicians becoming employed by hospitals and health systems
- “Favored nation physician groups formed that can be an ACO and deal with bundled payments and quality reporting
- Imaging becoming too unprofitable to engage in
- With competition among insurers-capitation will reemerge with a different name