Healthcare in the U.S.

CLS

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Healthcare in the U.S.

• Where we have been?
  • An abbreviated look at how the present system evolved

• Where are we now?
  • Highlights of the Accountable Care Act of 2010

• Where might we be headed?
  – Two Significant Trends in American Healthcare
    • Consolidation of Hospitals and Healthcare Systems
    • Trends in Physician Alignment

• The Value proposition for the Stakeholders

• These are very difficult, compelling, far reaching and intriguing questions.
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• Let us first Define our terms
• Who are we in that series of questions on the previous slide?
• We are the major stakeholders
  – The Patients
  – The Doctors
  – The Acute Care Hospitals
  – Healthcare Delivery Systems
  – The Government
  – The Insurance Industry
  – Private Industry
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• How did we get here?
Healthcare in the U.S. 1900-1920

- In 1901, AMA reorganizes as the national organization of state and local associations. Membership increases from about 8,000 physicians in 1900 to 70,000 in 1910 -- half the physicians in the country. This period is the beginning of "organized medicine."
- Surgery is now common, especially for removing tumors, infected tonsils, appendectomies, and gynecological operations.
- Railroads are the leading industry to develop employee medical programs.
Healthcare in the U.S. 1920-1930

• American hospitals are now modern scientific institutions, valuing antiseptics and cleanliness, and using medications for the relief of pain.

• Penicillin is discovered in 1928, but it will be twenty years before it is used to combat infection and disease.

• General Motors signs a contract with Metropolitan Life to insure 180,000 workers
U.S. Healthcare 1930’s

• The Depression changes priorities, with greater emphasis on unemployment insurance and "old age" benefits.
• Social Security Act is passed, omitting health insurance.
• Blue Cross begins offering private coverage for hospital care in dozens of states.
• The success of the Blue Cross and Blue Shield model encourages other insurers to enter the healthcare market.
U.S. Healthcare 1940’s

• After the war to compete for workers companies begin to offer health benefits, giving rise to the employer-based system in place today.

• Penicillin comes into use.

• Prepaid group healthcare begins, and is seen as radical.

• President Truman offers national health program plan, proposing a single system that would include all of American society which is denounced by the AMA.
U.S. Healthcare in 1950’s

- At the start of the decade, national health care expenditures are 4.5 percent of the Gross National Product.
- Many medications are available now to treat a range of diseases, including infections, glaucoma, and arthritis, and new vaccines become available that prevent dreaded childhood diseases, including polio. The first successful organ transplant is performed.
- Federal responsibility for the sick poor is firmly established.
U.S. Healthcare in 1960’s

• Now in the early 1960s, those outside the workplace, especially the elderly, have difficulty affording insurance.

• In 1965 Medicare legislation was passed consisting of two parts:
  – Part A covered hospital services
  – Part B covered doctors' services

• In addition to Medicare, Medicaid was enacted as a federal-state program to provide medical services for the indigent. Although both programs started small, expenditures in Medicare and Medicaid grow dramatically in the late 1960s as the programs began to gear up.

• Over 700 insurance companies selling health insurance.

• The number of doctors reporting themselves as full-time specialists grows from 55% in 1960 to 69%.

• Concern about a "doctor shortage" and the need for more "health manpower" leads to federal measures to expand education in the health professions.
U.S. Healthcare in 1970’s

• Healthcare costs are escalating rapidly, partially due to unexpectedly high Medicare expenditures, rapid inflation in the economy, expansion of hospital expenses and profits, and changes in medical care including greater use of technology, medications, and conservative approaches to treatment.

• President Nixon's plan for national health insurance rejected by liberals & labor unions, but his "War on Cancer" centralizes research at the NIH.
U.S. Healthcare in 1980’s

• Corporations begin to integrate the hospital system (previously a decentralized structure), enter many other healthcare-related businesses, and consolidate control.

• Under President Reagan, Medicare shifts to payment by diagnosis (DRG) instead of by treatment. Private plans quickly follow suit.

• "Capitation" payments to doctors become more common.
U.S. Healthcare in 1990’s

• Health care costs rise at double the rate of inflation.
• Federal health care reform legislation fails again to pass in the U.S. Congress.
• By the end of the decade there are 44 million Americans, 16% of the nation, with no health insurance at all.
• Human Genome Project to identify all of the more than 100,000 genes in human DNA gets underway.
U.S. Healthcare in 2000s

- Medicare is viewed by some as unsustainable under the present structure and must be "rescued".
- Changing demographics of the workplace lead many to believe the employer-based system of insurance can't last.
- Direct-to-consumer advertising for pharmaceuticals and medical devices is on the rise.
- The human genome is decoded.
The Two A’s Dominate the Discussion of Healthcare in 2009

• **Access** to healthcare - Nearly 16 percent of Americans, 44 million, are without health insurance

• **Affordability** of healthcare - Many Americans, with and without health insurance, face crippling financial debt from their medical care. Healthcare is the leading cause of bankruptcy in the U.S. even in those with insurance.
Healthcare in the US

• Where we are now?
  – We are in the process of implementing the Patient Protection and Affordable Care Act
  – What is the this?
US Healthcare in 2010

• On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law.
• The Patient Protection and Affordable Care Act of 2010 significantly changed health care in the U.S., making insurance available to between 32 - 50 million more Americans -- a total of 95% of the legal population.
• The law is being phased in over four years or slightly longer.
• Every citizen will be required to have insurance by March 31, 2014 or face a 1% income tax.
• If they already have a plan, through their employer, Medicaid, Medicare or privately, they can keep it (with some exceptions). For those who can’t get health coverage, they can purchase it from a health insurance exchange (possibly with a subsidy) or they may be eligible under expanded Medicare guidelines. Private insurance plans must contain 10 essential elements.
The ACA of 2010

• The new law was highly controversial right from the start. Because the Act is so complex anyone can easily pick out whichever facts support their particular point of view.

• General Principals:
  – The advantages mostly accrue to those who don't have health insurance, whether it's because of cost, employer or pre-existing health conditions.
  – The disadvantages accrue to those individuals and businesses who pay more taxes or incur higher operating costs.
How are the cost of coverage offset?

- The Act was designed to offsets its additional costs by:
  - Lowering payments to hospitals.
  - Increasing Medicare taxes on higher income households.
  - Assessing penalties on employers who don't offer, and individuals who don't take, health care insurance.
  - Assessing taxes on various health related activities.
  - Reducing overhead by consolidating the higher education loan program with the Pell Grant program.
ACA 2010 Phase in

- Small businesses received tax credits to cover up to 35% of their total employee premium payments. This increases to 50% in 2014.
- Indoor tanning services were assessed a 10% excise tax.
- A re-insurance program offset the costs of health benefits for workers age 55-64 who were forced into early retirement.
- Medicare beneficiaries who fell into the Medicare Part D Prescription Drug "donut hole" received a $250 rebate. They received a 50% discount on brand name drugs in 2011, and the donut hole is eliminated in 2020.
ACA 2010 Phase in

- Children were allowed to stay on their parents' health insurance until they turn 26.
- Private plans created after 2010 were required to cover preventive services with no co-payments, and they are exempt from deductibles. Consumers who applied to new plans have access to an external appeals process if coverage is denied.
- Insurance companies were prohibited from dropping coverage if someone got really sick. They couldn't create lifetime coverage limits. They could no longer deny coverage to children with pre-existing conditions. The same will apply to adults in 2014. Until then, adults with pre-existing conditions who have been denied coverage will get access to temporary health insurance coverage until the exchanges are set up.
ACA Phase in 2011

• Medicare-covered preventive services were exempted from deductibles and the co-pay was eliminated.

• Insurance companies must prove they spent at least 80% of the premium payments on medical services, rather than on things like advertising and executive salaries. Those that didn't were required to provide rebates to policyholders.

• States were funded to require health insurance companies to submit justification for all rate hikes.

• Funds were expanded to increase the number of doctors and nurses, and more community health centers -- enough to double the number of patients they can treat in the next five years.
ACA Phase in 2013

• Medical expenses must be at least 10% of income before they are deductible for those under 65.
• Manufacturers and importers of medical devices pay a 2.3% excise tax.
• The Federal government funded states to pay primary care physicians 100% of the Medicare fee.
• Medicare started a pilot program to encourage hospitals to bundle services before submitting for payment.
• Additional taxes were assessed on the 1 million people who make more than $200,000, and the 4 million couples filing jointly who made more than $250,000. Specifically, they paid a total of 2.35% (up from 1.45%)
• Families in most states could start shopping on the health insurance exchanges beginning October 1, 2013. Businesses with fewer than 50 employees could start in November.
ACA Phase in 2014

- Health insurance coverage bought through the exchanges begins.
- Medicaid eligibility is expanded to include those with incomes up to 133% of the Federal poverty level.
- New subsidies become available for those with incomes up to 400% of the poverty level ($95,400 for a family of four).
- Those who don't purchase insurance will be assessed a tax. The minimum is $95 per adult and $47.50 per child, capped at $285 per household. The maximum is 1% of adjusted gross income (AGI), capped at the cost of purchasing the "bronze" health insurance plan on the exchanges.
ACA Phase in 2014

- Businesses with 100+ workers must pay $2,000 per worker (except for the first 30) if they don’t offer health insurance.
- This applies to businesses with 50-99 employees in 2016.
Benefits of the ACA

- The Act was designed to reduce overall health care costs by making services available to the 32 million who currently can't get insurance. They often use a hospital emergency room as their primary care physician, increasing costs for everyone. This starts in 2014.

- It requires that all plans cover 10 essential health benefits. Preventive services are free, which lowers health care costs by treating diseases before they reach an expensive crisis.

- For people who can't afford health insurance, the Federal government will pay the states to add them to Medicaid. The income requirement is expanded up to 133% of the Federal poverty level - roughly $31,000 for a family of four.

- Those who don't qualify for expanded Medicaid receive tax credits if their income is below 400% of the poverty level ($94,000 for a family of four). States are required to set up insurance exchanges, or use the Federal government's exchange, to make it easier to shop for insurance plans.
Benefits of the ACA

• Insurance companies cannot deny children coverage for pre-existing conditions. This benefit applies to everyone in 2014. Insurance companies can no longer drop anyone from coverage once they get sick. If a company denies someone coverage, that person can go to an external appeals process.

• Parents can put their children up to age 26 on their health insurance plans. This increases profit for health insurance companies, since they receive more premiums without higher costs for these healthier individuals. As of 2012, more than three million previously uninsured young people were added.

• The Medicare "donut hole" gap in coverage is eliminated by 2020.
Benefits of the ACA

• People with existing health insurance can keep it (unless the provider drops it). Businesses prefer to offer a tax-free benefit like health insurance to attract good workers. That won't change.
• The ACA does not apply to businesses with less than 50 employees. Larger businesses are required to offer health insurance, but receive tax credits to help employees pay premiums.
• The Act lowers the budget deficit by $143 billion over the next 10 years by raising some taxes and shifting cost burdens to health care providers and pharmaceutical companies.
Disadvantages of the ACA

• There are 30.1 million people who currently buy their own private health insurance. Many of them have had their plans cancelled by the insurance company because the plan doesn't meet the 10 essential health benefits. Their costs of replacement insurance is higher because it provides services, like maternity care, that many of them don’t need.

• Between 3-5 million people could lose their company-sponsored health care plans. Many businesses will find it more cost-effective to pay the penalty and let their employees purchase their own insurance plans on the exchanges. Other small businesses might find they can get a better plan through the state-run exchanges.

• Increased coverage may actually raise overall health care costs in the short-term. That's because many people will receive preventive care and testing. These additional tests, such as cancer screening and cholesterol tests, will lead to higher medical spending.
Disadvantages of the ACA

- Those who don't purchase insurance by March 31, 2014, and don't qualify for Medicaid, will be assessed a tax of $95 (or 1% of income, whichever is higher) in 2014. It increases to $325 (or 2% of income) in 2015, and $695 (or 2.5% of income) in 2016.

- About 4 million people, or 1.2% of the population, will wind up paying the tax rather than purchase health insurance. The CBO estimates this will cost them $54 billion.

- Taxes were raised in 2013 on one million individuals on incomes exceeding $200,000 and four million couples filing jointly on incomes exceeding $250,000. They would pay a total of 2.35% (up from 1.45%) Medicare taxes on income above the threshold. They also pay an additional 3.8% Medicare taxes. This applies to the lesser of income from dividends, capital gains, rent and royalties or income above the threshold.
Disadvantages of the ACA

• In 2013, medical-device manufacturers and importers paid a 2.3% excise tax. Indoor tanning services pay a 10% excise tax. This could discourage those businesses from hiring new employees.

• In 2013, families could only deduct medical expenses that exceed 10% of income. Previously, they could deduct expenses that exceeded 7.5% of income.

• Pharmaceutical companies pay an extra $84.8 billion in fees over the next ten years to pay for closing the "donut hole" in Medicare Part D. This could raise drug costs if they pass this onto consumers.

• In 2018, insurance companies will be assessed a 40% excise tax on "Cadillac" health plans. These are plans with annual premiums exceeding $10,200 for individuals or $27,500 for families. Many of these plans are for people in high-risk pools, such as older workers or those with dangerous jobs. Most of the tax will be passed onto the companies or employees, raising premiums or deductibles.
Healthcare in the US

• Where we might be headed?
  – Two Significant Trends
    • Consolidation of Hospitals and Healthcare Systems
    • Trends in Physician Alignment
  – The Value proposition for the Stakeholders
Trends in the Consolidation of Hospitals and Healthcare Systems

• American Hospital Association (AHA) statistics reveal that in 1990, hospital systems (defined as two or more hospitals, organized under a common corporate structure) operated 44% of U.S. staffed inpatient beds. By 2011, that number exceeded 70%.

• In 2003, the largest 20 systems captured an estimated 23% of U.S. inpatient admissions, versus an adjusted 26% in 2011 — an average annual shift of only ~0.4% market share. The implication is that the largest hospital systems do not seem to be growing rapidly.

• A true national healthcare system has yet to emerge, let alone be on the verge of doing so.
Trends in the Consolidation of Hospitals and Healthcare Systems

- Approximately 65 (50%) formerly independent hospitals merged into large, regional systems (outside of the Top 20, with 50,000 or more admissions).

- Approximately 45 (35%) formerly independent hospitals merged into locally focused systems (outside of the Top 20, with fewer than 50,000 admissions).

- Key Drivers of Consolidation:
  - Growing concern about a more challenging operating environment.
  - Cost savings through scale economies and clinical service rationalization are viewed as a means to offset revenue erosion.
  - Large market shares/covered lives bases are viewed as imperative to successful managed care strategies
  - US debt markets’ preference for diversified scale is intensifying.
Trends in the Consolidation of Hospitals and Healthcare Systems

• The most successful among the healthcare systems are perceived by relevant payers as *the* “must-have” system within given markets.

• Regional systems with “must-have” status either treat a significant proportion of patient volumes and/or offer unique services across a given geography.

• “Must have “requirements:
  – Sizable, aligned physician bases, through formal structures and efficient operations
  – Strong local reputations and brands
  – Real or perceived quality and service advantages

• In addition to this smaller local or community systems musts include:
  – Achieve economies of scale as mechanisms to cut costs and offset per-unit revenue erosion.
  – Secure access to capital in sufficient quantity and at a workable cost, to maintain operations and invest in growth.
  – A mass sufficient scale across markets (covered lives) to efficiently accept risk
Trends in the Consolidation of Hospitals and Healthcare Systems

• Large health systems will attempt to achieve “must have” status in focused markets via acquisitions and/or partnerships or performance.

• Regional systems’ choices in navigating the crossroads to pursue super-regional agendas, partner to access scale economies and/or capital or remain regionally focused in the face of intensifying regulatory scrutiny.

• Local systems’ and independent hospitals’ attempts to balance desires for local control with desires to preserve missions in the face of mounting environmental/economic challenges.
Trends in Physician Alignment

• The previous standard of physicians operating independently is becoming increasingly untenable.

• Physicians and their chosen healthcare delivery partner must collaborate to build substantially larger, more scalable delivery platforms that ensure high-quality, low-cost care.

• Six focus areas are imperative to create high-performing physician groups.
Trends in Physician Alignment

• The previous standard of physicians operating independently is increasingly untenable.
  – due to general economic pressure
  – demographic changes in an aging society
  – decreasing reimbursement trends in both government and commercial payers causing downward pressure on cost
  – The need for access to capital for investment in clinical infrastructure and new technology
  – Increasing governmental oversight and regulation
Trends in Physician Alignment

• Economically unaligned practices are not scalable, market competitive, or able to provide the utmost level of coordinated care.
• The next generation of physician organizations, similar to their health systems or aligned partners, must perform at a higher level of efficiency, compared to their legacy practices, to achieve the clinical, operational and financial objectives required under the new environment of healthcare.
• The key to making consolidation pay off and achieving sustained success is excellence in execution.
Trends in Physician Alignment

- Types of Physician Alignment with Healthcare Delivery Systems.
  - Hospital owned physicians: Physicians on hospital payrolls increased by 34% from 2000 to 2010, with nearly 25% of practicing physicians employed by a hospital or health system.
  - Faculty Practice Plans: Nationally, the number of full-time faculty in clinical sciences, who make up the bulk of faculty, increased by 14% to nearly 125,000 from 2007 to 2012.
  - Independent Physician Practices: The number of physicians in this sector increased by 17%, from 2000 to 2011.
  - For-profit organizations: Large, for-profit healthcare companies are diversifying and acquiring doctor groups and clinics. –McKesson and Devita are for profit companies in the healthcare segment that have entered the market by purchasing large physician practices.
  - Government: Many physicians are employed to deliver care by a branch of the federal government or a department of the local government.
Trends in Physician Alignment

• Six focus areas are imperative to create high-performing physician groups.
  – New kinds of leadership: cultural and operational cohesiveness, the group must be transformed into an efficient, productive, evidence-based practice that delivers care across a wide clinical continuum.
  – Healthcare must transform to patient-centric model from today’s entity-centric model.
  – There is a compelling need for disciplined expense control, implementation of cost-efficient workflows and processes, and a streamlined operational platform.
  – Adoption of once-innovative payment models will become the norm as incentives for providers and payers move from volume to value.
  – Movement toward population health management. This creates the size, scale and scope for affordability.
  – Coordinated care management capability - properly executed patient handoff across the continuum of care.
Trends in Physician Alignment

• The models of Physician Alignment:
  – Professional Service Agreement
  – Accountable Care Organizations
  – Management Service Organizations
  – Clinically Integrated Network
Trends in Physician Alignment

• Doctors or groups of doctors contracting directly with the healthcare system.

• Physician employment and Professional Service Agreements (PSAs) have been one of the fastest-growing and most popular models with physicians.
Trends in Physician Alignment

- A healthcare MSO (Management Service Organization) is an organization owned by a group of physicians, a physician hospital joint venture or investors in conjunction with physicians.

- MSOs generally provide practice management and administrative support services to individual physicians and group practices. One purpose of MSOs is to relieve physicians of non-medical business functions.

- MSOs develop or secure comprehensive practice management services to support fully integrated practices. The practices typically are integrated through direct employment or Professional Services Agreement (PSA) relationships.
Trends in Physician Alignment

• An accountable care organization (ACO) is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patient.

• ACOs have gained traction as a cost savings mechanism in care delivery. ACOs are beginning to integrate physicians through joint managed care initiatives. These initiatives require a higher level of integration than traditional relationships, as there is an operational component to coordinate care among several providers per patient event.
A Clinically Integrated Network (CIN) is collaboration among independent/private practice and employed physicians and a hospital or health system, to develop a clinical integration program, which is an active and ongoing program of clinical initiatives to improve the quality and delivery of health care services, leading to greater efficiency in care delivery and cost savings.

CINs are developing relationships between payer, providers and systems. Beyond the joint payer contracting models in risk-based or messenger model approaches, high levels of clinical integration further qualify providers to utilize single signature contracting.
Trends in Physician Alignment

• As health systems build a high-performing medical group, the strategic imperative shifts from aggregation to coordination and integration. The pathway to performance requires several key steps, including:
  – Establishing “best practice” benchmarks
  – restructuring costs
  – coordinating clinical integration across the continuum of care
  – managing the variability of care and cost and the transfer of risk from payers to patients and providers.
Trends in Physician Alignment

• Expect at least 30–40% of the care delivered by physician organizations will be risk- and performance-based within five years, effectively putting the onus on delivering outcomes-based services and quality improvement metrics and goals, rather than the production-based incentives of the fee-for-service world.

• The market is challenging organizations to start with best practices, to earn the business rather than justify the cost, to embrace risk arrangements as the norm, and to realize that decisions are more consumer-driven.

• The challenges suggest that organizations that successfully respond will have the opportunity to grow, while those that do not will decline.

• Physician alignment is an essential component for successful delivery of coordinated, cost-effective care for our future.
The Value Proposition

• Once Healthcare systems & Physicians are aggregated and aligned which is a work in progress where do we go from here.

• The proposition going forward will be maximizing value for the patient at the lowest cost.
  – The focus is going to shifting from volume and profitability of individual services rendered to patient outcomes achieved. (This is a whole separate talk unto itself). This transition will not be linear or rapid and will involve multiple payment models with varying risk exposures.

  • This will require a fundamental paradigm change in the way healthcare is organized, measured and reimbursed.
    – Many institutions have already started major initiatives aimed at moving the value agenda forward.

  • Institutions that have adopted the value proposition should reap the benefit of improved outcomes, increased efficiency and growth in market share.
“The future is already here — it is just not very evenly distributed.” attributed to science fiction Guru William Gibson

Thank you