The Future of Health Care Reform and Managing Health Care Costs

Wharton School
February 1, 2017
Jeff Levin-Scherz, MD MBA FACP
Jeff.levin-scherz@willistowerswatson.com
jlevin@hsph.harvard.edu
www.managinghealthcarecosts.blogspot.com
Agenda

• Health Care Costs – dimensions of the problem
• Stakeholder evaluation – goals for health care reform
• Review of health care reform options
• Synthesis – elements of health care reform
Survey results

If you had to suggest one action that could be taken to control health care costs, what would it be?

- Prevention/public health: 6
- Payment Reform: 4
- End of life: 2
- Reduce Medicare coverage: 2
- Single payer: 2
- Cost Shift: 1
- Disease management: 1
- Downshift: 1
- Evidence based care: 1
- Insurer competition: 1
- Raise Medicare Eligibility: 1
- Regulate sugar: 1
## Cost Index

<table>
<thead>
<tr>
<th>Policy</th>
<th>Cost Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient cost shift</td>
<td>0.48</td>
</tr>
<tr>
<td>Prevention</td>
<td>0.79</td>
</tr>
<tr>
<td>Tort reform</td>
<td>0.36</td>
</tr>
<tr>
<td>Disease management</td>
<td>0.62</td>
</tr>
<tr>
<td>More PCPS</td>
<td>0.40</td>
</tr>
<tr>
<td>Health IT</td>
<td>0.36</td>
</tr>
<tr>
<td>Prohibit for profit</td>
<td>-0.07</td>
</tr>
<tr>
<td>Single payer</td>
<td>0.14</td>
</tr>
<tr>
<td>CapX Regs</td>
<td>0.10</td>
</tr>
<tr>
<td>Price Regs</td>
<td>0.43</td>
</tr>
<tr>
<td>Hosp Process</td>
<td>0.40</td>
</tr>
<tr>
<td>More nonMDs</td>
<td>0.60</td>
</tr>
<tr>
<td>Retail Clinics</td>
<td>0.38</td>
</tr>
<tr>
<td>Telemed</td>
<td>0.43</td>
</tr>
<tr>
<td>Mobile apps</td>
<td>0.29</td>
</tr>
<tr>
<td>Wearables</td>
<td>0.12</td>
</tr>
</tbody>
</table>

Lower $ a lot +1  
Lower $ a little +0.5  
Raise cost a little -0.5  
Raise cost a lot -1
Impact on Quality

- Improve quality
- No change in quality
- Make quality worse
- I'm not sure
### Quality Impact

<table>
<thead>
<tr>
<th>Policy</th>
<th>Quality Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient cost shift</td>
<td>-0.33</td>
</tr>
<tr>
<td>Prevention</td>
<td>0.81</td>
</tr>
<tr>
<td>Tort reform</td>
<td>0.33</td>
</tr>
<tr>
<td>Disease management</td>
<td>0.76</td>
</tr>
<tr>
<td>More PCPS</td>
<td>0.29</td>
</tr>
<tr>
<td>Health IT</td>
<td>0.67</td>
</tr>
<tr>
<td>Prohibit for profit</td>
<td>-0.33</td>
</tr>
<tr>
<td>Single payer</td>
<td>-0.48</td>
</tr>
<tr>
<td>CapX Regs</td>
<td>-0.43</td>
</tr>
<tr>
<td>Price Regs</td>
<td>-0.48</td>
</tr>
<tr>
<td>Hosp Process</td>
<td>0.80</td>
</tr>
<tr>
<td>More nonMDs</td>
<td>0.30</td>
</tr>
<tr>
<td>Retail Clinics</td>
<td>0.00</td>
</tr>
<tr>
<td>Telemed</td>
<td>0.30</td>
</tr>
<tr>
<td>Mobile apps</td>
<td>0.25</td>
</tr>
<tr>
<td>Wearables</td>
<td>0.25</td>
</tr>
</tbody>
</table>

**Improve quality** +1  
**Worsen quality** -1
Likelihood Index

Patient cost shift: 0.38
Prevention: -0.14
Tort reform: -0.19
Disease management: 0.00
More PCPS: -0.38
Health IT: 0.38
Prohibit for profit: -0.86
Single payer: -0.83
CapX Regs: -0.67
Price Regs: -0.45
Hosp Process: 0.25
More nonMDs: 0.28
Retail Clinics: 0.43
Telemed: 0.38
Mobile apps: 0.43
Wearables: 0.43

Very Likely +1
Likely +0.5
Unlikely -0.5
Very unlikely -1
Health care trends are low – but remain above CPI and “buydowns” continue

Health Care Trend After Plan Changes (Total Plan Costs)  Health Care Trend Before Plan Changes  CPI-U

*Projected.

Sample: Companies with at least 1,000 employees.

US Health Care Spending Appears Anomalous

Figure 2. Health Care Spending per Capita and GDP per Capita, 2004

Source: Congressional Research Service (CRS) analysis of OECD Health Data 2006 (October 2006).
Correlation Between Per Capita Expenditure on Health Care And GDP

Correlation Between Per Capita Expenditure on Health Care And GDP, 1998

\[ y = 318.747129e^{0.000074x} \]

\[ R^2 = 0.837564 \]

Source: OECD Health Data 2001. Data on Israel was taken from the web: www.scottish.parliament.uk/whats_happening/research/pdf_res_notes/m01-88.pdf. * Israel figures are for the year 2000.
America the outlier

Health-care spending
As % of GDP

United States
Germany
Switzerland
Canada
Japan
Sweden
Britain
OECD average

Hospital productivity in the United States*
Cumulative % change since 2002

Pneumonia

Heart attack

Heart failure

2002 03 04 05 06 07 08 09 10 11

Health-care spending in the United States
As % of GDP

Total national health

Medicare

1960 70 80 90 00 05 10 13

Sources: OECD; Bureau of Economic Analysis; Centres for Medicare and Medicaid Services; Health Affairs

*Labour and capital used for each successful treatment

Medical Inflation Persistently Outpaces Overall Inflation & Worker Earnings

Total Premium Increases for Covered Workers with Family Coverage, 2001-2016

Source: Kaiser Family Foundation/HRET, 2016
Crowd-Out is Real: MA State Budget

Figure A: State budgets for health care coverage and other priorities - FY01 vs. FY14

Billions of dollars

- $5.48B (+37%)
- $3.68B (-17%)

GIC, MassHealth, and other coverage
-22.2%
-31.1%
-12.2%
-11.1%
-14.0%
-13.2%
-50.5%

Mental Health
Public Health
Education
Human Services
Infrastructure, Housing & Economic Development
Law & Public Safety
Local Aid

NOTE: Figures all adjusted for GDP growth
Source: Figures all adjusted for GDP growth
Source: Massachusetts Budget and Policy Center
Tradeoff: Medicaid vs. Education

Medicaid spending appears to explain the vast majority of the decline in higher education appropriations per capita.

Kane and Orszag, Brookings, 2003

Tradeoff: Medicaid vs. Education

Medicaid spending appears to explain the vast majority of the decline in higher education appropriations per capita.

Kane and Orszag, Brookings, 2003

Mortality for US whites increased from 2000-2013

Reference: Case and Deaton, Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century PNAS 2015

LINK
Concentration of Health Spending

Source: Peterson KFF Tracker, 2013
Many contributions to health care costs are outside of the health care system

- Factors that can lower medical costs include
  - Clean water
  - Clean air
  - Better “built environment” that encourages healthy behavior
  - Social support systems that do not “medicalize” social problems
  - Programs to decrease smoking and excess alcohol use
Health Care Paradox: Social vs. Health Care Spending

Source: OECD, Health at a Glance 2009: OECD Publishing
See: http://managinghealthcarecosts.blogspot.com/2014/02/the-health-care-paradox-us-combined.html
Factors Accounting For Growth In Per Capita National Health Expenditures And Personal Health Care Expenditures, Selected Calendar Years 2004–11.

Total value of malpractice payments has decreased substantially since peak in ~2000

Source: Lincoln, Taylor. "No Correlation: Continued Decrease in Medical Malpractice Payments Debunks Theory That Litigation Is to Blame for Soaring Medical Costs." Available at SSRN (2013)
Most preventive services are cost-effective; few are cost-saving

Medical Cost Implications Per Person Per Year

- Childhood Vaccinations: $(267)
- All Other Prev Services: $219
- Total Saved: $(48)

Source: Health Affairs  Maciosek, Health Affairs 2010
http://content.healthaffairs.org/content/29/9/1656.full
Prevalence of high deductibles is increasing

Source: KFF HRET 2016 Employer Health Benefits Survey
Portion of Compensation Gains Lost To Health Benefits

Source: Towers Watson 2010
Exhibit 1. Rising Health Insurance Premiums Disproportionately Affect Low-Wage Workers

Notes: All figures are adjusted for inflation (2012 dollars; BLS Urban Consumer Price Index).

Medical bills are a major cause of bankruptcy in the US

Causes of Bankruptcy (US 2007)

- Any medical cause: 62.1%
- Lost income due to illness: 40.3%
- High medical bills or mortgaged home for medical bills: 57.1%

The ACA’s taxes are largely levied on the rich

FIGURE 1
Repeal all Affordable Care Act Taxes
Percent change in after-tax income by expanded cash income percentile, 2017


Source: Vox.com
Stakeholder evaluation

• Groups
  – Patients
  – Physicians
  – Hospitals
  – Pharma/medical device
  – Health Plans
  – Businesses
  – Government

Identify the top 3 things that your stakeholder group would want from health care reform in the US, and at least two meaningful concessions you would be willing to make

- Identify reporter (1 min)
- Brainstorm (12 min)
- Prioritize (7 min)

Reporter from group will describe findings to class
Break
Public policy goals of health care reform

For class discussion
Elements of health care reform

- How is health care funded?
  - Dedicated or general taxes
  - Insurance premiums (individual or employer)
  - Out of pocket
- How does government subsidize medical care?
  - Payment vs. tax credit vs. tax deduction vs. not at all
- How is risk pooled?
  - Community, employer, union or association, other
- Cross subsidization
  - By income (wealthy → poor)
  - By health needs (healthy → sick)
- How are providers paid?
  - Fee for service, bundled, capitation, hybrid
- How are providers arranged?
  - Private independent practice
  - Employed by delivery systems
  - Government employed
- How much does government intervene?
  - US federal vs. state role
A few final thoughts on managing health care costs….

<table>
<thead>
<tr>
<th>Conclusion</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The problem in the US is price – not utilization</td>
<td>If we repriced US health care at Canadian (or western European) prices, there would be no “health care cost crisis”</td>
</tr>
<tr>
<td>A small portion of the population represents a large portion of total health care costs</td>
<td>Programs aimed at the “healthy” are not likely to save big bucks!</td>
</tr>
<tr>
<td>Cost effective ≠ Cost saving</td>
<td>Health care value can be increased even absent cost savings</td>
</tr>
<tr>
<td>Fee for service encourages increased utilization and self-dealing</td>
<td>Capitation encourages underutilization and discourages providers from caring for those with serious illness</td>
</tr>
<tr>
<td>Providers can increase value through accountable care organizations</td>
<td>Provider consolidation can also increase prices</td>
</tr>
<tr>
<td>Lowering health care costs is hard</td>
<td>Every “wasted” dollar is someone’s income</td>
</tr>
</tbody>
</table>
Appendix Slides:

Republican Affordable Care Act Replacement Proposal
Key elements of selected Republican replacement plans

<table>
<thead>
<tr>
<th></th>
<th>Ryan</th>
<th>Hatch</th>
<th>Price</th>
<th>Cruz</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Mandate</strong></td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Preexisting Conditions</strong></td>
<td></td>
<td>Continuous Coverage</td>
<td>No Protection</td>
<td></td>
</tr>
<tr>
<td><strong>Essential Benefits</strong></td>
<td></td>
<td></td>
<td>Eliminated</td>
<td></td>
</tr>
<tr>
<td><strong>Subsidies</strong></td>
<td>Down Age-based</td>
<td>Down Age &amp; income</td>
<td>Down Age-based</td>
<td>None</td>
</tr>
<tr>
<td><strong>Age band</strong></td>
<td>5 to 1</td>
<td>5 to 1</td>
<td>No regs</td>
<td>No regs</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>Block</td>
<td>Block</td>
<td>Block</td>
<td>Repeal</td>
</tr>
<tr>
<td><strong>Employer tax exclusion</strong></td>
<td></td>
<td>Eliminate</td>
<td>Retain</td>
<td></td>
</tr>
</tbody>
</table>

https://www.washingtonpost.com/graphics/national/obamacare-replacement-plans/
Cassidy-Collins Bill
Patient Freedom Act of 2017

• Three options by state
  1. Keep ACA
  2. State alternative option (Roth HSAs)
  3. Reject all federal funding

• Key Elements:
  – Funding decreased to 95% of current federal funding
    • State alternative spreads 95% of funding over much larger group – leaving lower subsidies for those <400% FPL
  – Many insurance reforms eliminated
  – First dollar preventive care eliminated if employer funds HSA

Appendix Slides: Affordable Care Act
# The ten titles of the Affordable Care Act

<table>
<thead>
<tr>
<th>Title</th>
<th>Contents</th>
<th>Elements</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title I</td>
<td>Health Insurance Reforms</td>
<td>Regulates insurance market; no rescission, limits waiting &amp; caps, MLR, sets up exchanges, defines essential benefits, mandates, subsidies, adult kids</td>
<td>Increased value (and cost) of insurance; Substantial subsidies for those under 400% of FPL</td>
</tr>
<tr>
<td>Title II</td>
<td>Medicaid, CHIP</td>
<td>Standard Medicaid eligibility at 133% of FPL; no CHIP cuts</td>
<td>Higher enrollment – less due to Supreme Court decision allowing states to opt out</td>
</tr>
<tr>
<td>Title III</td>
<td>Medicare</td>
<td>Cuts to Medicare Advantage and hospital cuts; phased elimination of Medicare D donut hole, payment advisory board</td>
<td>Cuts in projected increases</td>
</tr>
<tr>
<td>Title IV</td>
<td>Public Health</td>
<td>Public health funds, wellness programs, menu disclosures</td>
<td>Increased public health funding</td>
</tr>
<tr>
<td>Title V</td>
<td>Workforce</td>
<td>Advisory committee; support for primary care training; redistribute unused slots</td>
<td>Funding to address shortages</td>
</tr>
<tr>
<td>Title VI</td>
<td>Fraud</td>
<td>Medicare database; allow credentialing</td>
<td>Decreased Medicare costs</td>
</tr>
<tr>
<td>Title VII</td>
<td>Biosimilars</td>
<td>Roadmap for approvals</td>
<td>Biosimilars can decrease cost</td>
</tr>
<tr>
<td>Title VIII</td>
<td>CLASS – REPEALED</td>
<td>Voluntary insurance to provide for home care to avoid nursing home</td>
<td>Insurance scheme that showed cash-based balance in first 10 years</td>
</tr>
<tr>
<td>Title IX</td>
<td>Revenue</td>
<td>Excise tax for high cost health plans, ↑ Part A for wealthy; taxes on pharma, health plans and device companies</td>
<td>Taxes and fees to fund subsidies</td>
</tr>
<tr>
<td>Title X</td>
<td>Manager’s Amendment</td>
<td>Any changes agreed to by House and Senate as part of reconciliation process</td>
<td>Changes limited to budget items; no “conference committee” to harmonize bill</td>
</tr>
</tbody>
</table>
Selected health insurance reforms of the ACA

- Essential benefits
- No lifetime or annual max
- Guarantee issue
- No rescission
- Coverage to age 26
- 3:1 premium ratio by age only

- Minimum medical loss ratio
- Individual mandate
- Employer mandate
Provider payment reforms

- **ACA**
  - Centers for Medicare and Medicaid Innovation
    - Joint replacement and cardiac surgery reimbursement programs have sought to drive change in care delivery

- **MACRA (Medicare Access and Chip Reauthorization Act, 2015)**
  - Removed SGR mandatory Medicare pay cuts
  - Offered alternatives to “meaningful use” for providers in payment reform programs
Affordable Care Act: Subsidies

- Advanceable tax credit for 133-400% FPL (cost capped at 2-9.5% of income)
  - No subsidy for <133% of FPL
- Cost sharing subsidies for those especially under 200% of FPL (94% actuarial value plan, max OOP $2k/$4k)
- Medicaid expansion
  - Made optional by state by Supreme Court decision (Nat Fed of Indep Bus vs. Sebelius, 2012)
Funding the Affordable Care Act

**Revenue**
- Health Plan, Pharma and Med Device Tax ($165B)
- Increased Medicare Part A Tax >$200K ($318B)
- Indiv penalty ($56B)
- Employer penalty ($106B)
- “Cadillac tax” ($111B)

**Expenditures**
- Hospital fee increases ($415B)
- Medicare Advantage payments ($156B)
- Disproportionate share ($57B)
- Biosimilars
- Fraud, waste and abuse

All estimates for 10 years from 2010-2019
Current Status of State Medicaid Expansion Decisions

Source: http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/
Coverage Options for Parents as of January 2014 in States Not Moving Forward with the Medicaid Expansion at this Time

Eligibility levels are for parents of dependent children in a family of three.

SOURCE: Based on data from the Centers for Medicare and Medicaid Services, available at:
http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-

Appendix slides:
Provider payment
Where is the US health care dollar being spent?

<table>
<thead>
<tr>
<th></th>
<th>Medicare</th>
<th>Commercial</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>★★★★★★</td>
<td>★★</td>
<td>★★</td>
</tr>
<tr>
<td>Amb Facility</td>
<td>★★</td>
<td>★★★</td>
<td>★★</td>
</tr>
<tr>
<td>Professional</td>
<td>★★★★★</td>
<td>★★★</td>
<td>★★★☆</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>★★</td>
<td>-</td>
<td>☆</td>
</tr>
<tr>
<td>Hospice</td>
<td>★</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Maternity</td>
<td>-</td>
<td>★★</td>
<td>★★★★★</td>
</tr>
</tbody>
</table>
Beyond Capitation: How New Payment Experiments Seek To Find The ‘Sweet Spot’ In Amount Of Risk Providers And Payers Bear
Optimal **System** Payment Methodology

<table>
<thead>
<tr>
<th></th>
<th>Capitation</th>
<th>Fee For Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historic utilization rate</td>
<td>Overutilization</td>
<td>Underutilization</td>
</tr>
<tr>
<td>Available evidence of best practice</td>
<td>Good</td>
<td>Not good</td>
</tr>
<tr>
<td>Historic provider margin</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Ease of defining included services</td>
<td>High</td>
<td>Low</td>
</tr>
</tbody>
</table>
Capitation **does** focus physician attention on resource utilization.

**Slide 51**

**HEALTH ECONOMICS**

**OPERATING ON COMMISSION:**
ANALYZING HOW PHYSICIAN
FINANCIAL INCENTIVES AFFECT
SURGERY RATES

**JASON SHAFRIN**

...switching specialist compensation from capitation to FFS increased total (outpatient) surgery rates by 78%...

In the absence of referral requirements, changing PCP compensation from FFS to capitation increased total surgeries rates by 35%. When referral requirements are in place, however, this relationship disappears...
Physicians are more likely to prescribe treatment associated with high margins for their practices

Source: NEJM 2013
Provider allowable disparities are large and the “market” doesn’t “fix” them.

Source: Mass. Health Policy Commission, 2016 Blog Post
Concentration by Hospital Referral Region

Herfindahl-Hirschman Index (HHI) of Market Concentration

- Unconcentrated (HHI 100 to <1500)
- Moderately concentrated (HHI 1500 to <2500)
- Highly concentrated (HHI ≥2500)
- Not located in any hospital referral region

Cutler, JAMA 2013

Vertical consolidation further increases delivery system leverage