The Future of U.S. Healthcare:

"Obamacare", Medicare Payment Policy, and the Elusive Quest for Better Incentive Alignment

The Miller Center
University of Virginia
December 6, 2013

Rick Mayes, Ph.D.
Associate Professor of Public Policy, Department of Political Science
Co-Director, Healthcare & Society Program
University of Richmond

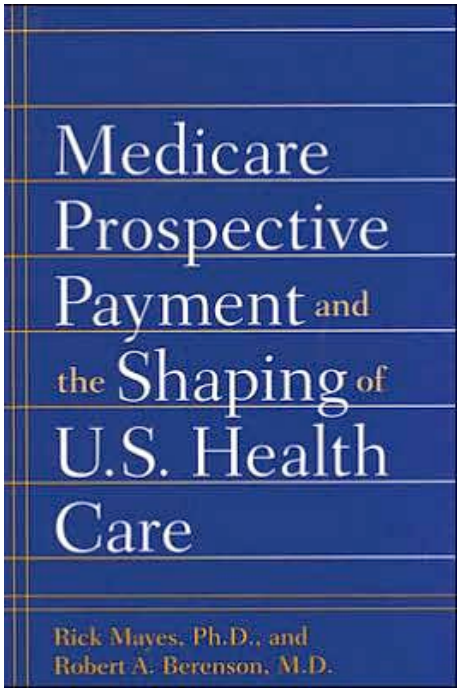
ORGANIZATION

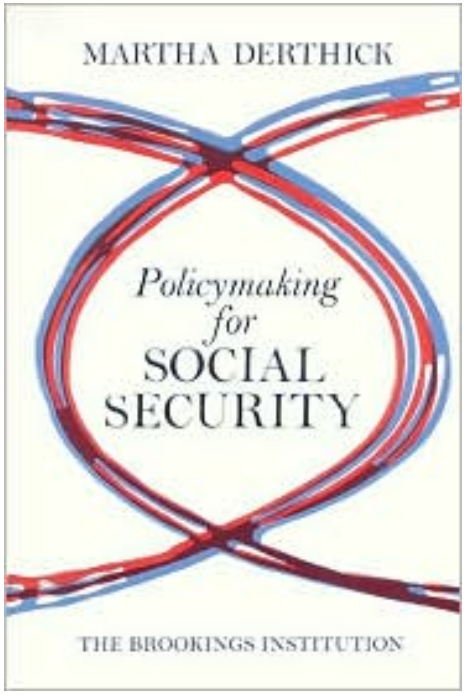
I. **How We Got Here**: Medicare's shaping of U.S. healthcare

II. **Where We Are Going**: current cost trends and the ACA's acceleration of the significant consolidation going on among medical providers, resulting in fewer, larger and (*hopefully*) more efficient health systems

III. **Q&A**

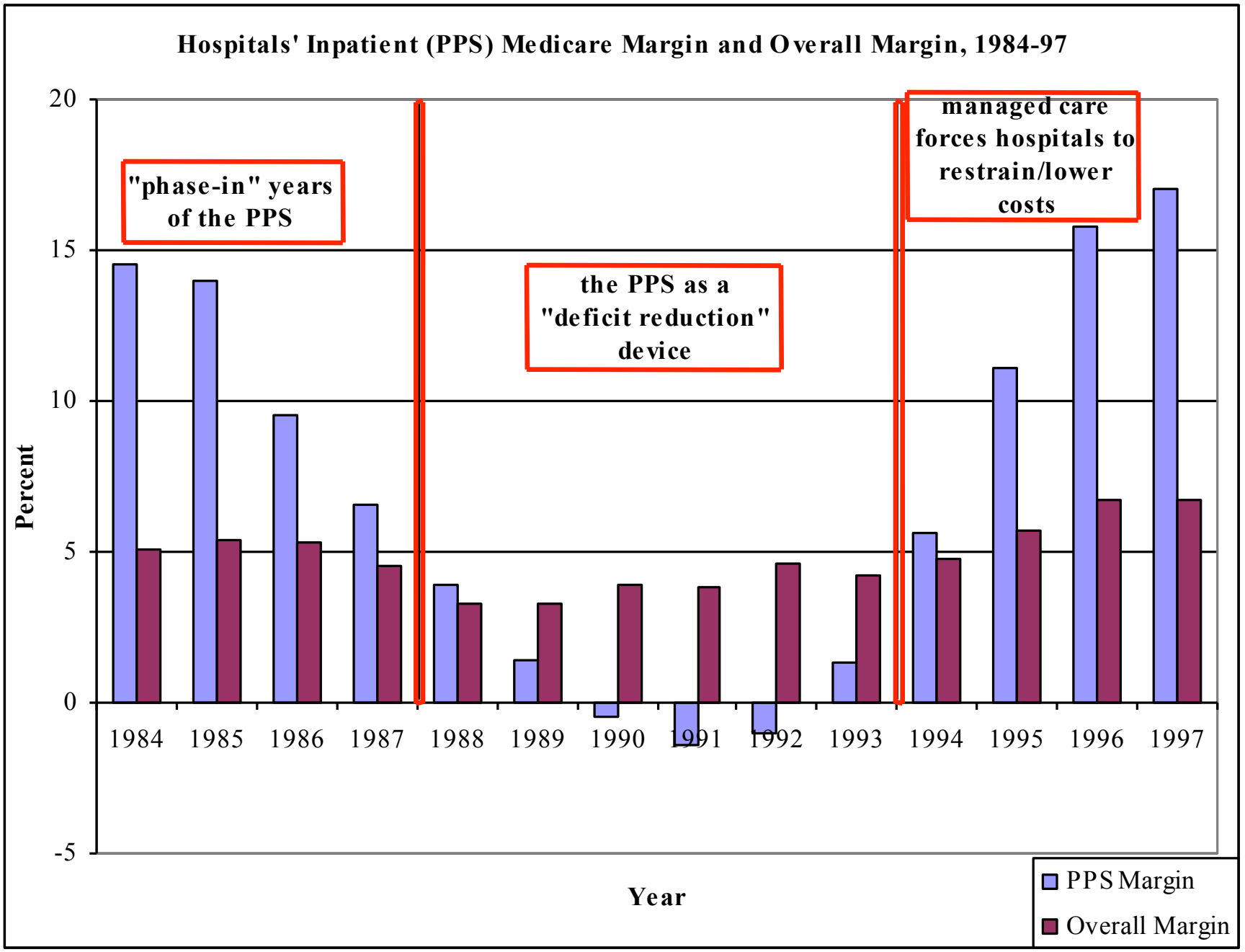
The biggest and most intense battle within the U.S. health care system during the past two decades has been over two interrelated questions: first, who will control the manner in which medical care is paid for, and second, how much will it cost? The primary argument of this book is that—contrary to conventional wisdom and whole libraries of books and articles that point to managed care as the biggest "change agent" in American medicine in the last twenty years—the private sector neither initiated this battle nor provided the critical innovation that transformed health care in the United States. Instead, it was Medicare's transition to a prospective payment system (PPS)



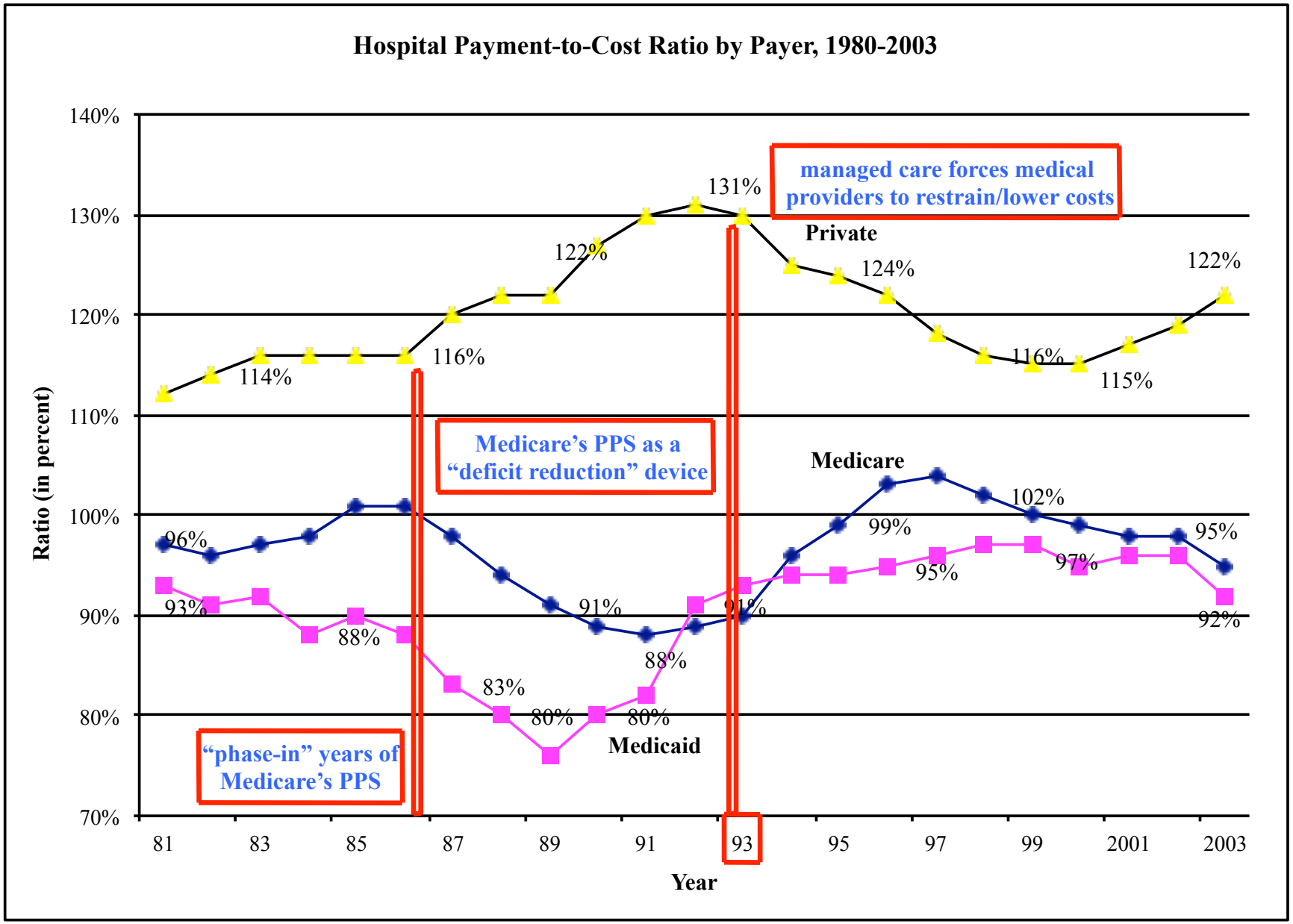


I. How We Got Here...30 Years Ago

The Modern Era of U.S. Health Care Begins (1983)



Source: Adapted and modified from MedPAC and American Hospital Association's Annual Survey of Hospitals, 2000.



Source: American Hospital Association's Annual Survey of Hospitals (n=6,800 hospitals), 2005.
Pearson's correlation coefficients:

1984-1997: Medicare and Private ratios: r = -.86
1984-1997: Medicaid and Private ratios: r = -.39
1980-2003: Medicare and Private ratios: r = -.73
1980-2003: Medicaid and Private ratios: r = -.56

National Health Expenditures per Capita

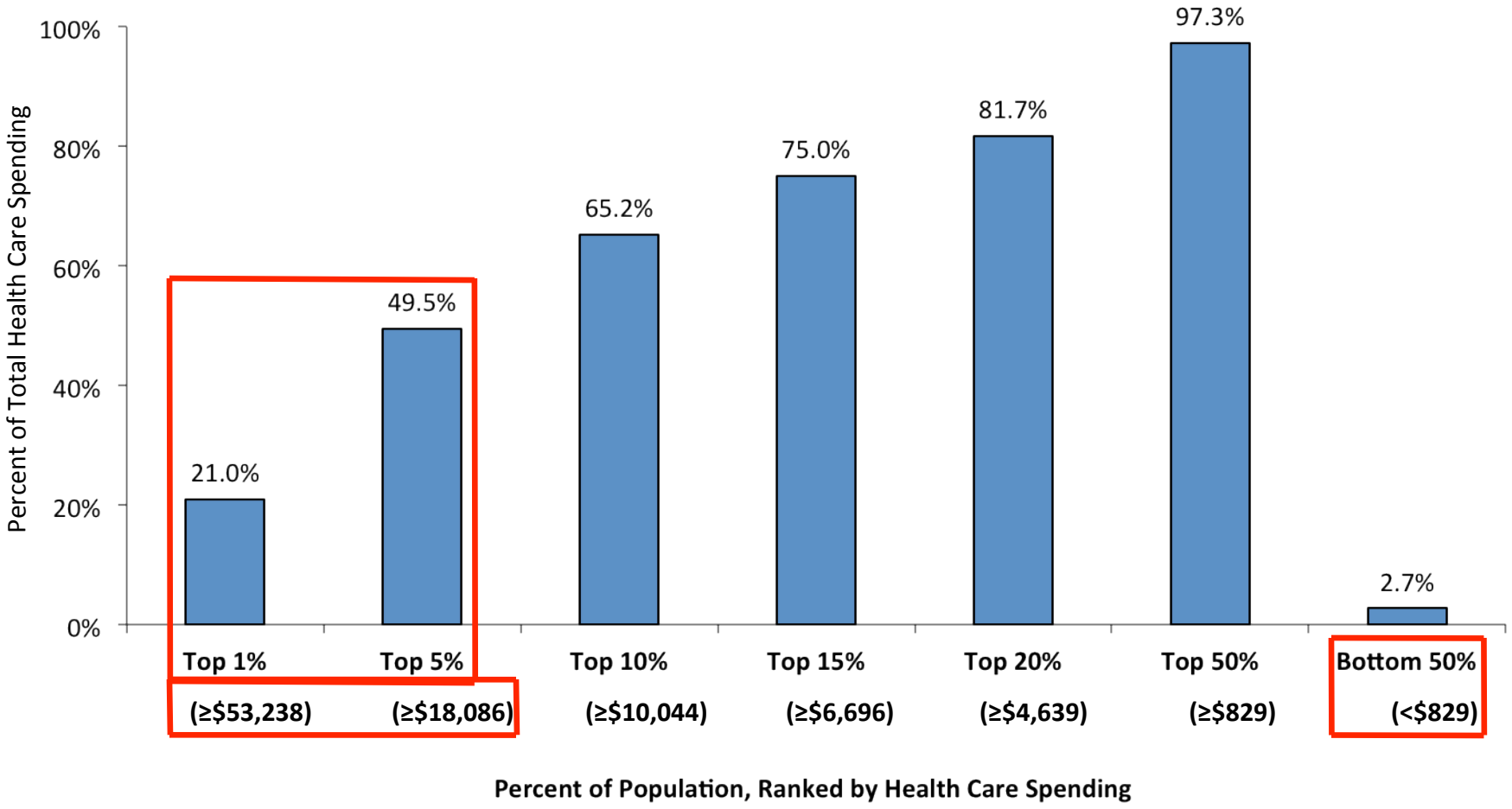
	1960	1970	1980	1990	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
NHE	$147	$356	$1,112	$2,851	$4,884	$5,240	$5,687	$6,122	$6,490	$6,883	$7,259	$7,635	$7,917	$8,174	$8,414	$8,684
NHE as a Share of GDP	5.2%	7.2%	9.2%	12.5%	13.8%	14.5%	15.4%	15.9%	16.0%	16.1%	16.2%	16.4%	16.8%	17.9%	17.9%	17.9%

NOTE: According to CMS, population is the U.S. Bureau of the Census resident-based population, less armed forces overseas and their dependents.

SOURCE: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see National Health Expenditures by type of service and source of funds; file nhe11.zip); Gross Domestic Product data from Bureau of Economic Analysis, at http://bea.gov/national/index.htm#gdp (file gdplev.xls).

THE HENRY J. KAISER FAMILY FOUNDATION

Concentration of Health Care Spending in the U.S. Population, 2010

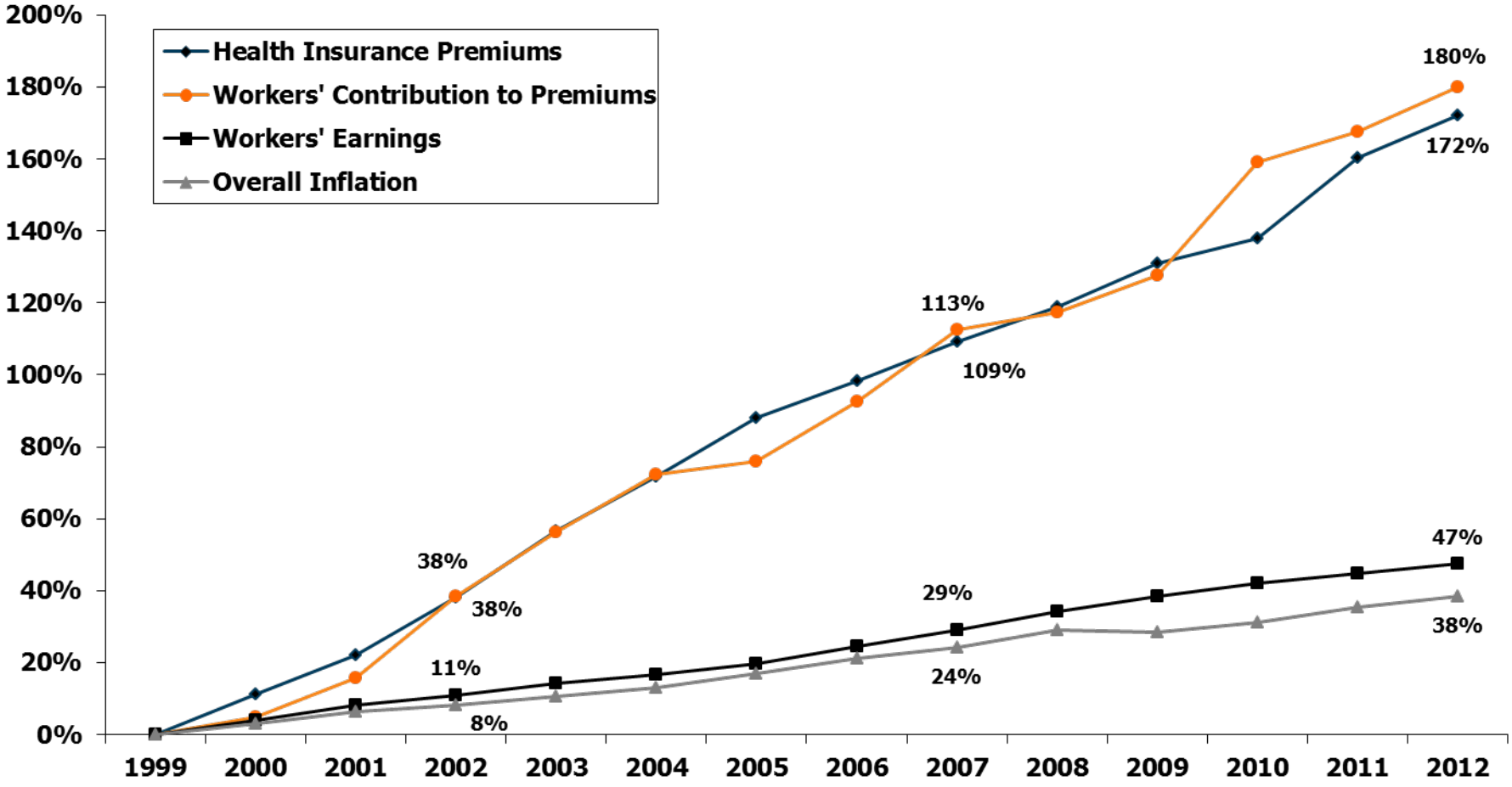


NOTE: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

SOURCE: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), Household Component, 2010.

CONSUMERS: WHERE HAVE WORKERS' RAISES GONE?

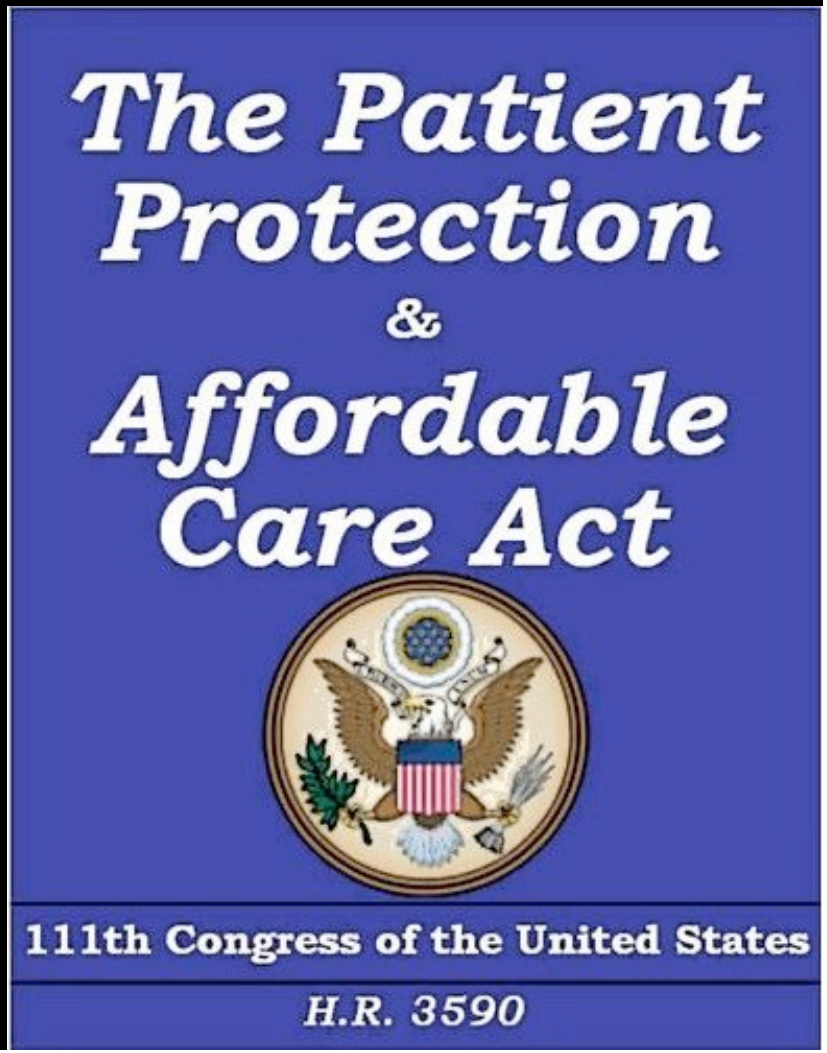
Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2012



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2012; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2012 (April to April).

II. Where We Are Going

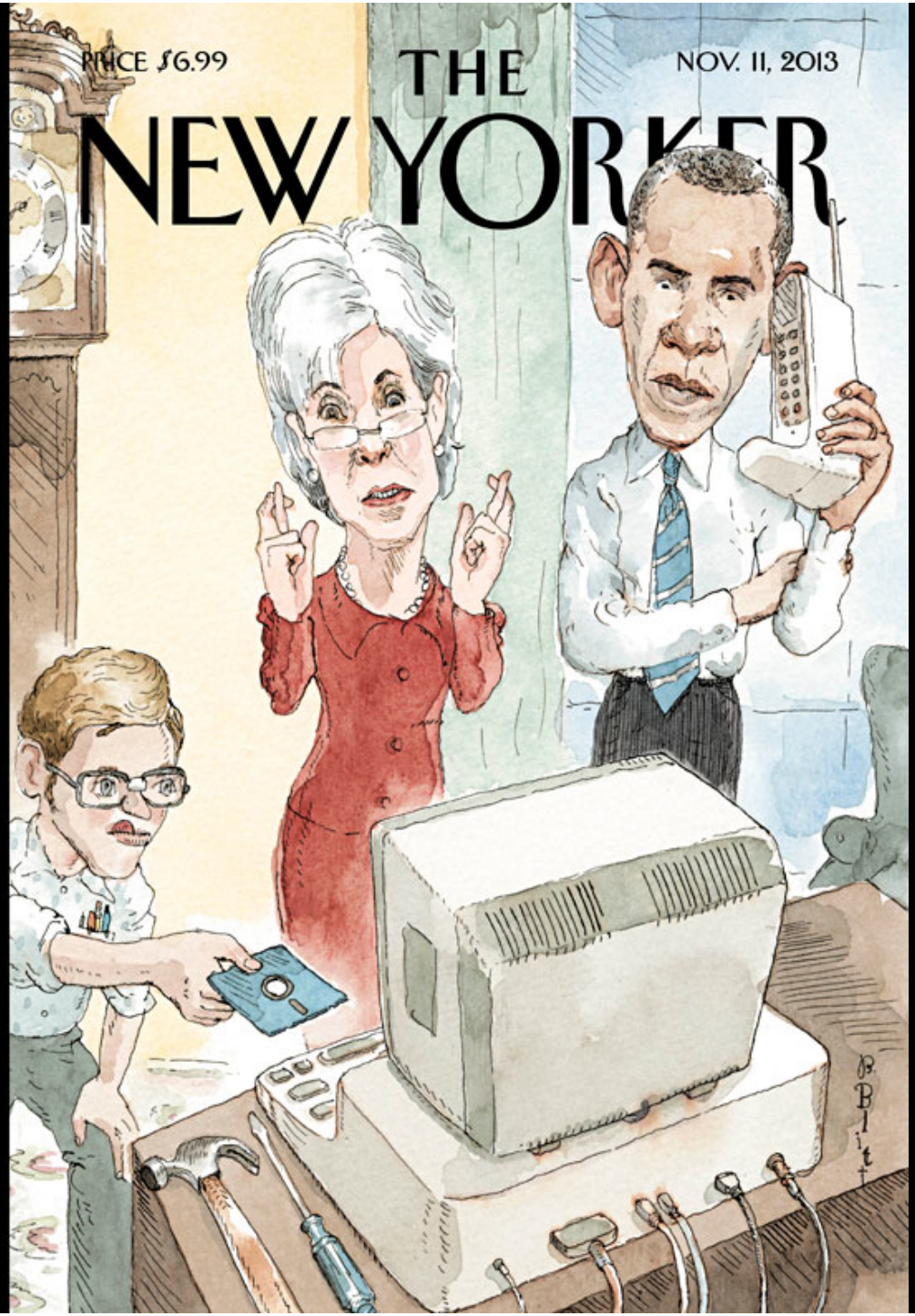
(Trying) to Move Away from Volume- to Value-Based Health Care Reimbursement



President Obama's Insularity:

"I was not informed directly that the website would not be working the way it was supposed to. Had I been informed, I wouldn't be going out saying, boy, this is going to be great. I'm accused of a lot of things, but I don't think I'm stupid enough to go around saying, this is going to be like shopping on Amazon or Travelocity a week before the website opens if I thought that it wasn't going to work."

Pres. Obama 11/14/13



President Obama's Disconnect:

May 11, 2010

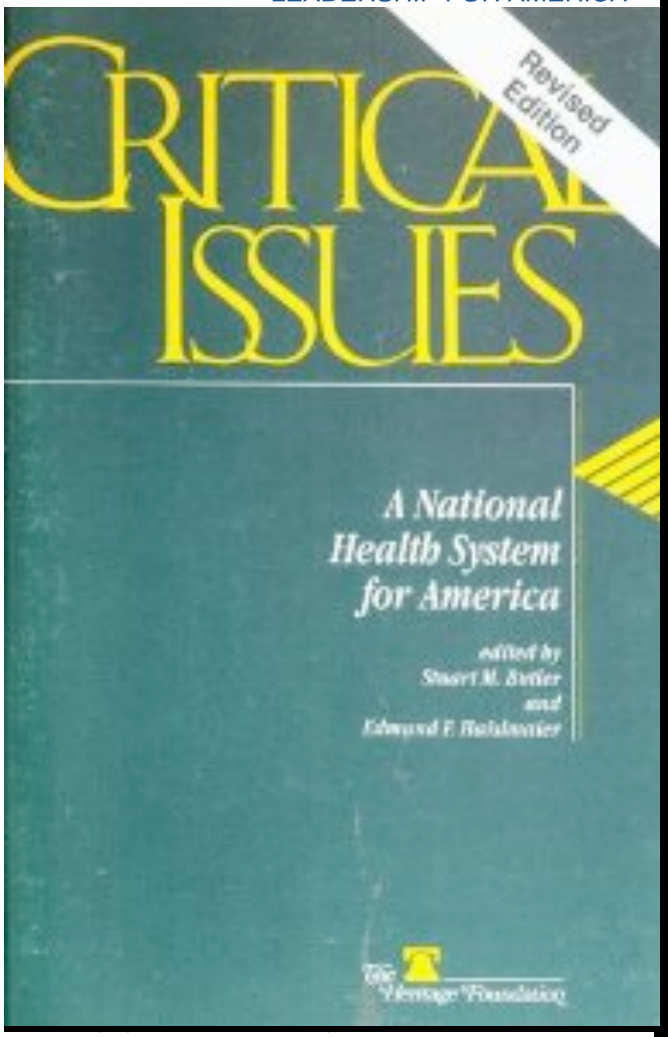
To: Larry Summers

From: David Cutler

Subject: Urgent Need for Changes in Health Reform Implementation

"I am writing to relay my concern about the way the Administration is implementing the new health reform legislation. I am concerned that the personnel and processes you have in place are not up to the task, and that health reform will be unsuccessful as a result."

The Heritage Foundation
LEADERSHIP FOR AMERICA



THE WALL STREET JOURNAL.
WSJ.com

BEST OF THE WEB TODAY | February 8, 2012

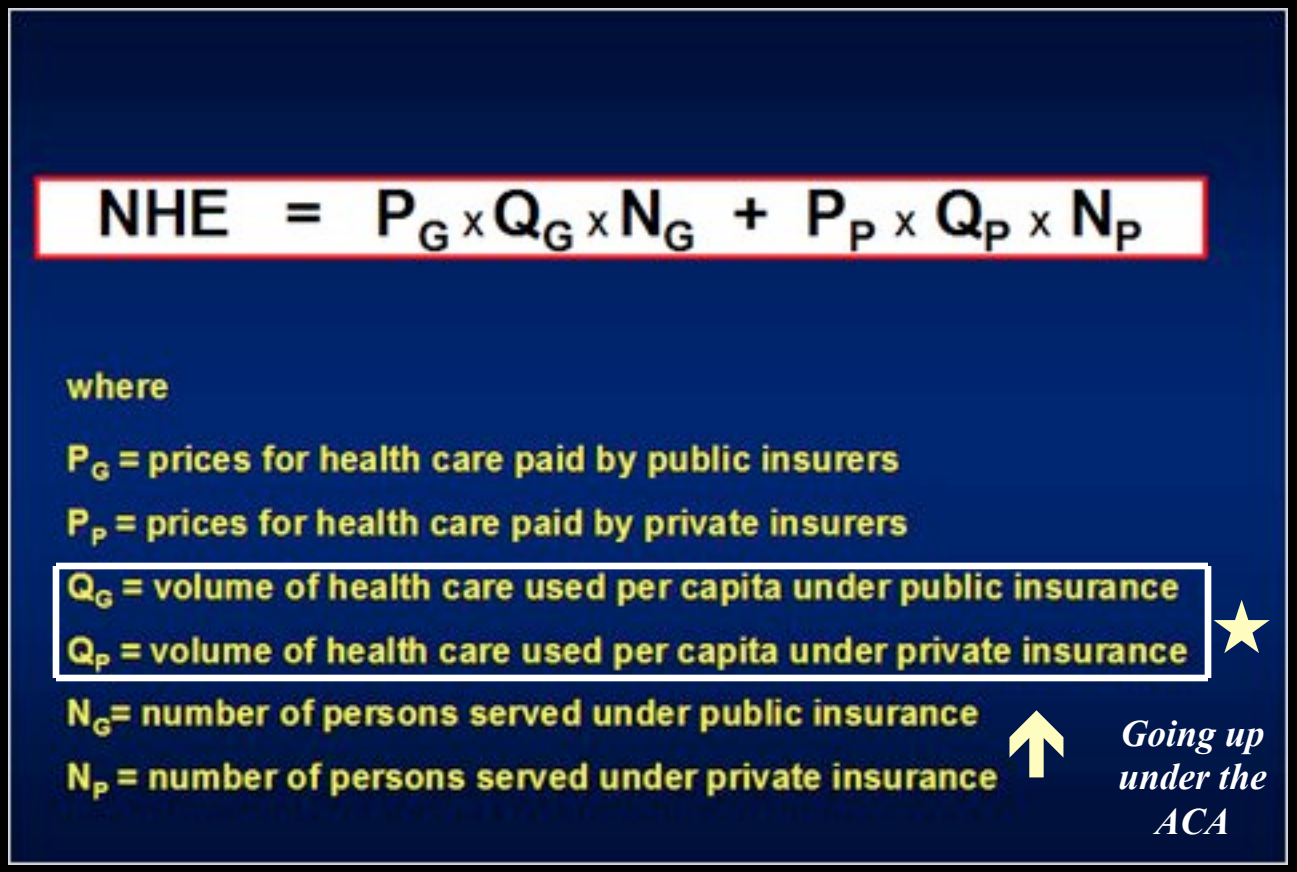
Heritage Rewrites History

The think tank proposed the individual mandate years before Clinton took office.

A LITTLE HISTORICAL PERPSECTIVE on the POLITICAL ROOTS of the ACA / "OBAMACARE"

Stuart Butler – June 1, 1989: "Many states now require passengers in automobiles to wear seatbelts for their own protection. Many others require anybody driving a car to have liability insurance. But neither the federal government nor any state requires all households to protect themselves from the potentially catastrophic costs of a serious accident or illness. **Under the Heritage Plan, there would be such a requirement**... The requirement to obtain basic insurance would have to be enforced. The easiest way to monitor compliance might be for households to furnish proof of insurance when they file their tax returns... If the family did not enroll in another plan before the first insurance coverage lapsed and did not provide evidence of financial problems, a **fine** would be imposed... Also, a new index of eligibility would be developed to link [expanded] Medicaid coverage to poverty instead of welfare. This is an important distinction, because many poor families struggling to keep off welfare currently risk enormous and uncovered medical bills because they are not eligible, or do not seek, to go on to the welfare rolls."

The Only Options for Controlling Costs



★ ***One of the ACA's primary goals is to lower the volume of preventable and expensive care by "incentivizing" (paying for) both better health promotion and a more restrained use of expensive medical resources when less intensive, equally effective and cheaper alternatives exist.***

An example of how a health care system's organization and method of paying providers has significant financial consequences for treating a very similar population of patients: ***Medicare beneficiaries in their last two years and six months of life.***

The Costs of Chronic Care

The intensity and cost of care provided to Medicare patients with chronic illnesses vary widely among academic medical centers.

Five top-ranked academic medical centers	AVERAGE PER PATIENT: **Medicare spending** in the last two years of life	**Hospital days** in the last six months of life	**Physician visits** in the last six months of life
U.C.L.A. Medical Center	$93,842	18.5	52.8
Johns Hopkins Hospital	$85,729	16.5	28.9
Massachusetts General Hospital	$78,666	17.3	39.5
Cleveland Clinic Foundation	$55,333	14.8	33.1
Mayo Clinic (St. Marys Hospital)	$53,432	12.0	23.9

Source: Dartmouth Atlas of Health Care

SOUNDING BOARD

Phasing Out Fee-for-Service Payment

Steven A. Schroeder, M.D., and William Frist, M.D.,
for the National Commission on Physician Payment Reform

In March 2012, the Society of General Internal Medicine convened the National Commission on Physician Payment Reform to recommend forms of payment that would maximize good clinical outcomes, enhance patient and physician satisfaction and autonomy, and provide cost-effective care. The formation of the commission was spurred by the recognition that the level of spending on health care in the United States is unsustainable, that the return on investment is poor, and that the way physicians are paid drives high medical expenditures.

The commission began by examining factors driving the high level of expenditures in the U.S. health care system. It found that reliance on technology and expensive care, higher payments for medical services performed in hospital-owned facilities than in outpatient facilities, and a high proportion of specialist physicians as compared with generalists were all important cost drivers. But fee-for-service reimbursement stood out as the most important cause of high health care expenditures.

costs in the United States.[1] It contains incentives for increasing the volume and cost of services (whether appropriate or not), encourages duplication, discourages care coordination, and promotes inefficiency in the delivery of medical services.

Recommendation 2: The transition to an approach based on quality and value should start with testing new models of care over a 5-year period and incorporating them into increasing numbers of practices, with the goal of broad adoption by the end of the decade.

The long-range solution is a system that provides appropriate and high-quality care, emphasizes disease prevention and the management of chronic conditions rather than treatment of illness, and values examination and diagnosis as much as medical procedures. This implies a shift from a payment system based on a fee-for-service model to one based on value through mechanisms such as bundled payment, capitation, and increased financial risk sharing. But

Another example: Prostate Cancer

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Mortality Results from a Randomized Prostate-Cancer Screening Trial

Gerald L. Andriole, M.D., E. David Crawford, M.D., Robert L. Grubb III, M.D., Saundra S. Buys, M.D., David Chia, Ph.D., Timothy R. Church, Ph.D., Mona N. Fouad, M.D., Edward P. Gelmann, M.D., Paul A. Kvale, M.D., Douglas J. Reding, M.D., Joel L. Weissfeld, M.D., Lance A. Yokochi, M.D., Barbara O'Brien, M.P.H., Jonathan D. Clapp, B.S., Joshua M. Rathmell, M.S., Thomas L. Riley, B.S., Richard B. Hayes, Ph.D., Barnett S. Kramer, M.D., Grant Izmirlian, Ph.D., Anthony B. Miller, M.B., Paul F. Pinsky, Ph.D., Philip C. Prorok, Ph.D., John K. Gohagan, Ph.D., and Christine D. Berg, M.D., for the PLCO Project Team*

ABSTRACT

BACKGROUND

The effect of screening with prostate-specific–antigen (PSA) testing and digital rectal examination on the rate of death from prostate cancer is unknown. This is the first report from the Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial on prostate-cancer mortality.

METHODS

From 1993 through 2001, we randomly assigned 76,693 men at 10 U.S. study centers to receive either annual screening (38,343 subjects) or usual care as the control (38,350 subjects). Men in the screening group were offered annual PSA testing for 6 years and digital rectal examination for 4 years. The subjects and health care providers received the results and decided on the type of follow-up evaluation. Usual care sometimes included screening, as some organizations have recommended. The numbers of all cancers and deaths and causes of death were ascertained.

RESULTS

In the screening group, rates of compliance were 85% for PSA testing and 86% for digital rectal examination. Rates of screening in the control group increased from 40% in the first year to 52% in the sixth year for PSA testing and ranged from 41 to 46% for digital rectal examination. After 7 years of follow-up, the incidence of prostate cancer per 10,000 person-years was 116 (2820 cancers) in the screening group and 95 (2322 cancers) in the control group (rate ratio, 1.22; 95% confidence interval [CI], 1.16 to 1.29). The incidence of death per 10,000 person-years was 2.0 (50 deaths) in the screening group and 1.7 (44 deaths) in the control group (rate ratio, 1.13; 95% CI, 0.75 to 1.70). The data at 10 years were 67% complete and consistent with these overall findings.

CONCLUSIONS

After 7 to 10 years of follow-up, the rate of death from prostate cancer was very low and did not differ significantly between the two study groups. (ClinicalTrials.gov number, NCT00002540.)

The authors' affiliations are listed in the Appendix. Address reprint requests to Dr. Berg at the Division of Cancer Prevention, National Cancer Institute, National Institutes of Health, 6130 Executive Blvd., Rm. 3112, Bethesda, MD 20892-7346, or at bergc@mail.nih.gov.

*Members of the Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial project team are listed in the Supplementary Appendix, available with the full text of this article at NEJM.org.

This article (10.1056/NEJMoa0810696) was published at NEJM.org on March 18, 2009.

N Engl J Med 2009;360:1310-9.

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Urologists' Use of Intensity-Modulated Radiation Therapy for Prostate Cancer

Jean M. Mitchell, Ph.D.

ABSTRACT

BACKGROUND

Some urology groups have integrated intensity-modulated radiation therapy (IMRT), a radiation treatment with a high reimbursement rate, into their practice. This is permitted by the exception for in-office ancillary services in the federal prohibition against self-referral. I examined the association between ownership of IMRT services and use of IMRT to treat prostate cancer.

METHODS

Using Medicare claims from 2005 through 2010, I constructed two samples: one comprising 35 self-referring urology groups in private practice and a matched control group comprising 35 non–self-referring urology groups in private practice, and the other comprising non–self-referring urologists employed at 11 National Comprehensive Cancer Network centers matched with 11 self-referring urology groups in private practice. I compared the use of IMRT in the periods before and during ownership and used a difference-in-differences analysis to evaluate changes in IMRT use according to self-referral status.

RESULTS

The rate of IMRT use by self-referring urologists in private practice increased from 13.1 to 32.3%, an increase of 19.2 percentage points (P<0.001). Among non–self-referring urologists, the rate of IMRT use increased from 14.3 to 15.6%, an increase of 1.3 percentage points (P=0.05). The unadjusted difference-in-differences effect was 17.9 percentage points (P<0.001). The regression-adjusted increase in IMRT use associated with self-referral was 16.4 percentage points (P<0.001). The rate of IMRT use by urologists working at National Comprehensive Cancer Network centers remained stable at 8.0% but increased by 33.0 percentage points among the 11 matched self-referring urology groups. The regression-adjusted difference-in-differences effect was 29.3 percentage points (P<0.001).

CONCLUSIONS

Urologists who acquired ownership of IMRT services increased their use of IMRT substantially more than urologists who did not own such services. Allowing urologists to self-refer for IMRT may contribute to increased use of this expensive therapy. (Funded by the American Society for Radiation Oncology.)

From Georgetown University, Washington, DC. Address reprint requests to Dr. Mitchell at Georgetown University, Old North 314, 37th & O Sts. NW, Washington, DC 20057, or at mitchejm@georgetown.edu.

N Engl J Med 2013;369:1629-37.
DOI: 10.1056/NEJMsa1201141

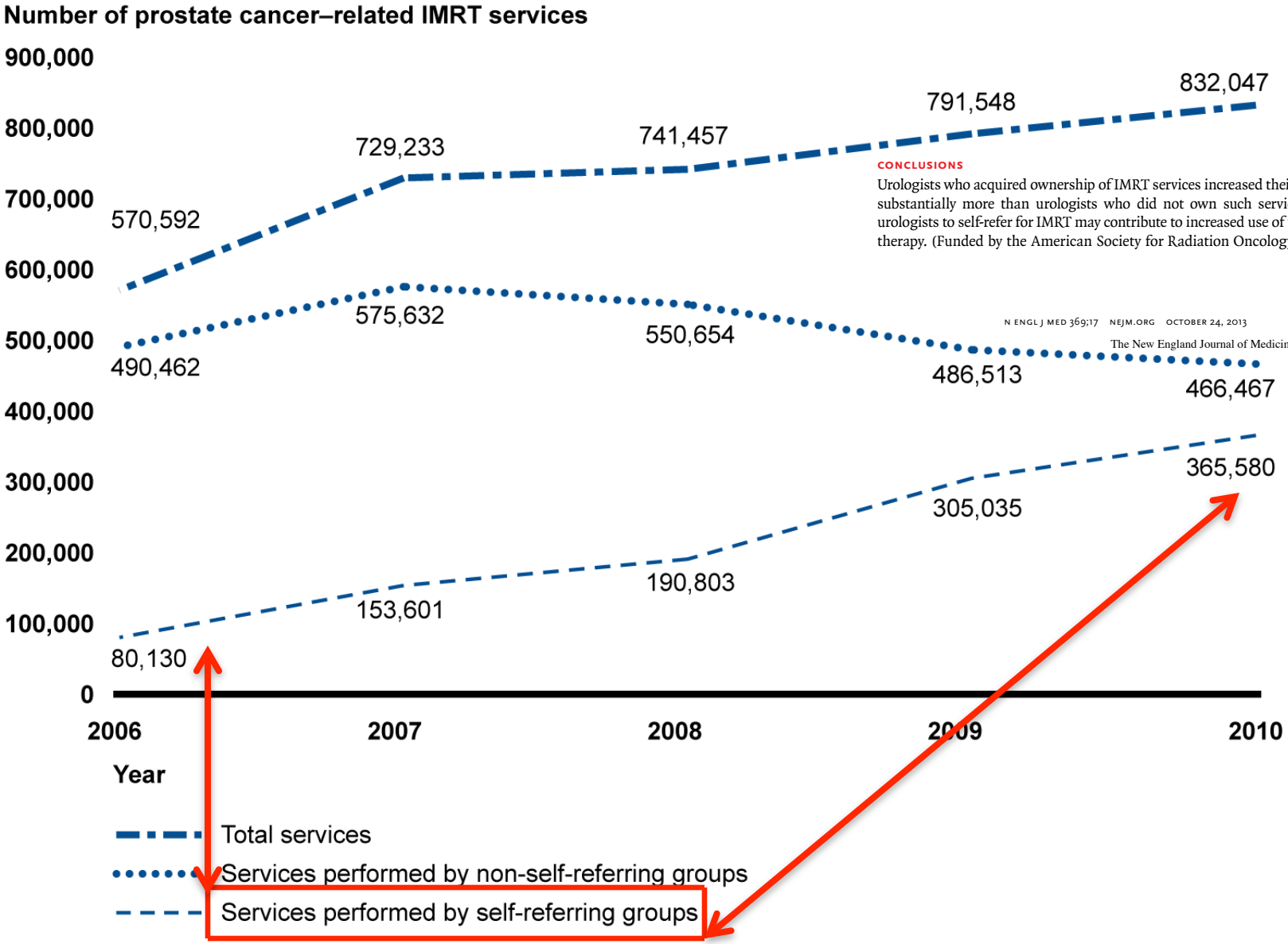
At What Cost?

Average spending for two years of prostate cancer treatment, based on the initial strategy, for patients who have the disease diagnosed.

TREATMENT	AVERAGE COST
Watchful waiting *Active plan to postpone intervention, usually with exams and testing.*	$ 2,436
External beam radiation therapy *Multiple doses of radiation over several weeks.*	$12,224
Radical prostatectomy *Complete surgical removal of prostate gland.*	$22,921
Brachytherapy *Implantation of radioactive seeds*	$28,872
Intensity-modulation radiation therapy (I.M.R.T.) *Advanced radiation beam therapy targeted at tumor.*	$51,069

Sources: Alan Garber and Daniella J. Penroth, Stanford; Dana P. Goldman, the RAND Corp.

Figure 1: Number of Medicare Prostate Cancer–Related IMRT Services Performed by Self-Referring and Non-Self-Referring Groups in Physician Offices, 2006-2010



Source: GAO analysis of CMS data.

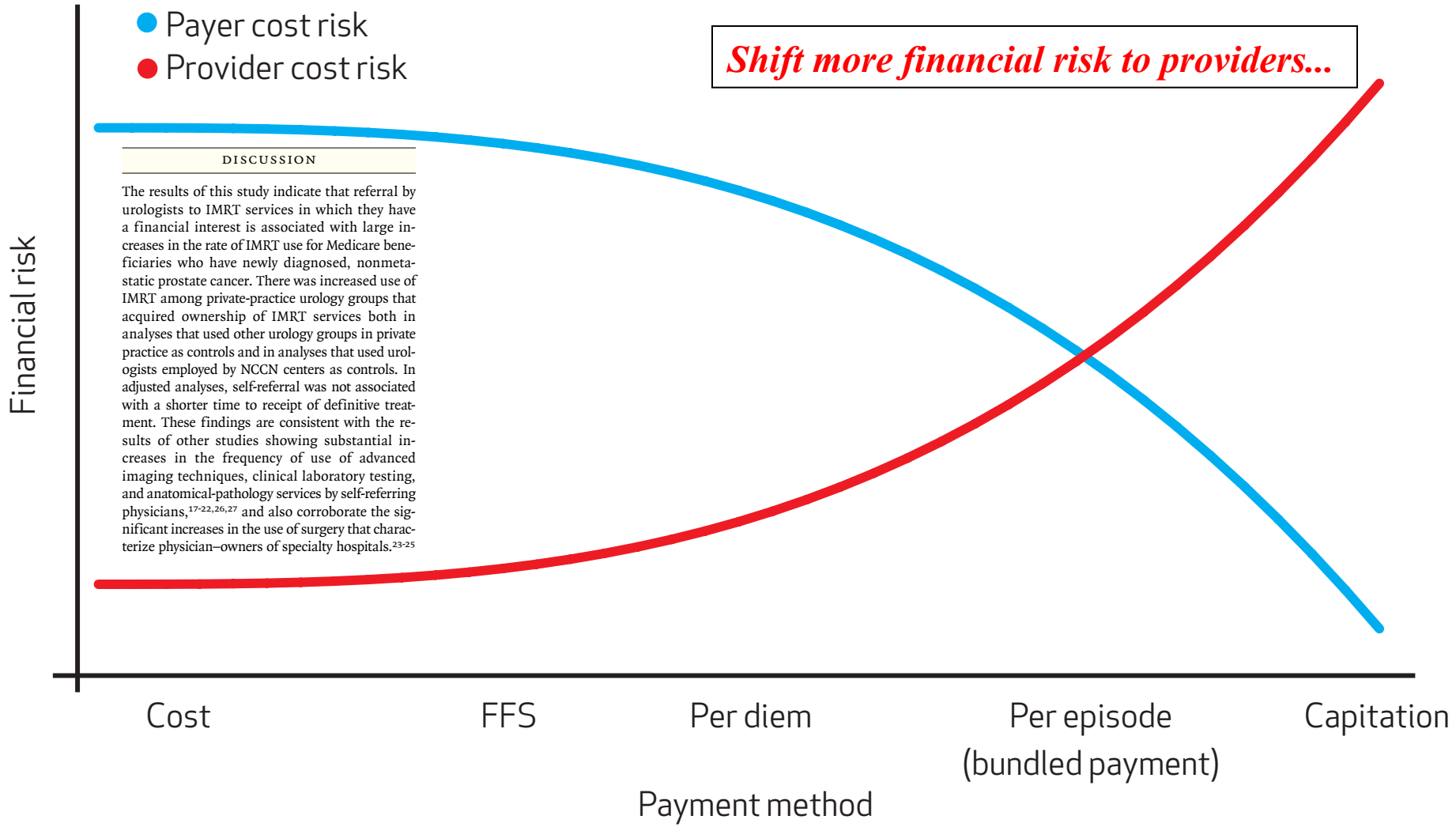
CONCLUSIONS

Urologists who acquired ownership of IMRT services increased their use of IMRT substantially more than urologists who did not own such services. Allowing urologists to self-refer for IMRT may contribute to increased use of this expensive therapy. (Funded by the American Society for Radiation Oncology.)

N ENGL J MED 369;17 NEJM.ORG OCTOBER 24, 2013
The New England Journal of Medicine

EXHIBIT 1

Financial Risk Of Care For Provider And Payer, By Payment Method



DISCUSSION

The results of this study indicate that referral by urologists to IMRT services in which they have a financial interest is associated with large increases in the rate of IMRT use for Medicare beneficiaries who have newly diagnosed, nonmetastatic prostate cancer. There was increased use of IMRT among private-practice urology groups that acquired ownership of IMRT services both in analyses that used other urology groups in private practice as controls and in analyses that used urologists employed by NCCN centers as controls. In adjusted analyses, self-referral was not associated with a shorter time to receipt of definitive treatment. These findings are consistent with the results of other studies showing substantial increases in the frequency of use of advanced imaging techniques, clinical laboratory testing, and anatomical-pathology services by self-referring physicians,[17-22,26,27] and also corroborate the significant increases in the use of surgery that characterize physician–owners of specialty hospitals.[23-25]

Bundled Payments for Entire Episodes of Care

Bypass by the Book

Geisinger Health System has devised an approach to elective heart bypass surgery, which it calls ProvenCare, that includes a 40-item checklist to ensure that patients get recommended treatments. A Geisinger study of the first-year results of the program found that fewer patients returned to the intensive care unit and that they were more likely to go directly home from the hospital rather than to a nursing home.

ProvenCare checklist for heart bypass surgery

1. **Before admission**
   12 checks, including screening for stroke risk.
2. **Just before and during surgery**
   8 checks, including confirming that the patient received the correct doses of medications and was screened for hyperglycemia.
3. **After surgery**
   10 checks, including tobacco screening and counseling.
4. **Before being discharged**
   4 checks, including making sure the patient understands medications and has been referred for cardiac rehabilitation.
5. **Follow-up**
   6 checks, including whether the patient is taking the medications correctly and is enrolled in a cardiac rehab program.

Some results of using ProvenCare

	Before	After
Patients with any complication	39.0%	35.0%
Supplemental blood products used	23.0	16.0
Discharged not to home	19.0	9.0
Readmission within 30 days	6.6	5.1
Any pulmonary complications	7.3	2.6
Re-operation for bleeding	3.6	2.6
Readmission to I.C.U.	2.9	0.9
In-hospital mortality (deaths)	1.5	0.0

Study based on 137 patients before and 117 after the debut of ProvenCare for a one-year period that ended in February of this year. Not all differences are statistically significant.

GEISINGER HEALTH PLAN®

more "skin in the game" for providers

I hate this whole G— d— system [Medicare]. I'd blow it up if I could, but I'm stuck with it. If it were up to me, I'd buy everybody private insurance and forget about it. Obviously that's what the Republican view is: We ought to do what we do for federal employees—go out and buy every senior citizen a community-rated, structured, and regulated private insurance plan. Let them all go buy an Aetna product, or a Blue Cross product; that's the Republican philosophy. Why should Tom Scully and his staff fix prices for every doctor and hospital in America? Which is what we do.

—Tom Scully, Administrator (2001–4), Centers for Medicare and Medicaid Services, President and CEO (1995–2001), Federation of American Hospitals

The New York Times
Opinionator

Unlike individual medical providers, accountable care organizations can afford to have more "skin in the game" and act as financial risk managers.

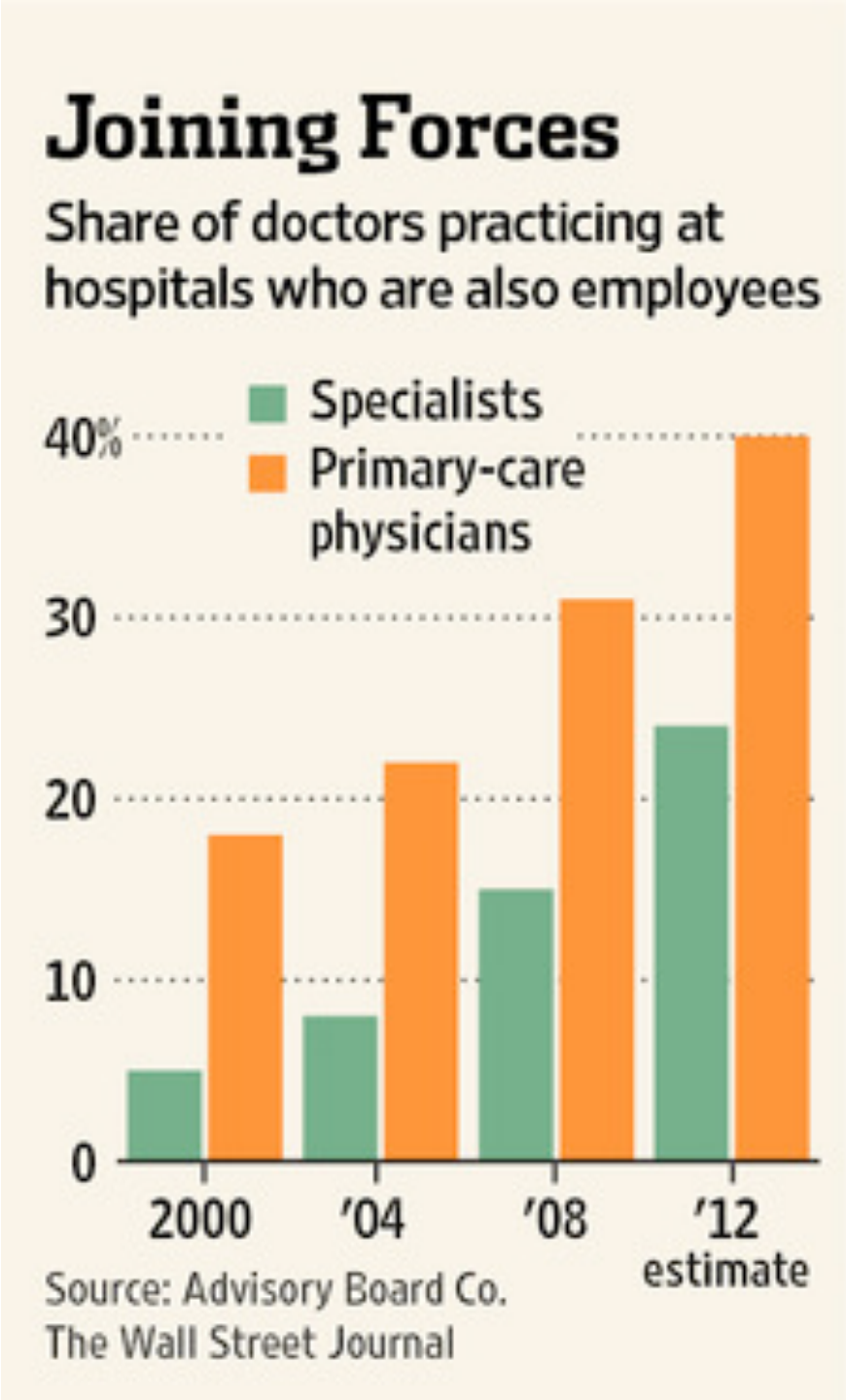
JANUARY 30, 2012, 9:00 PM

The End of Health Insurance Companies

By EZEKIEL J. EMANUEL and JEFFREY B. LIEBMAN

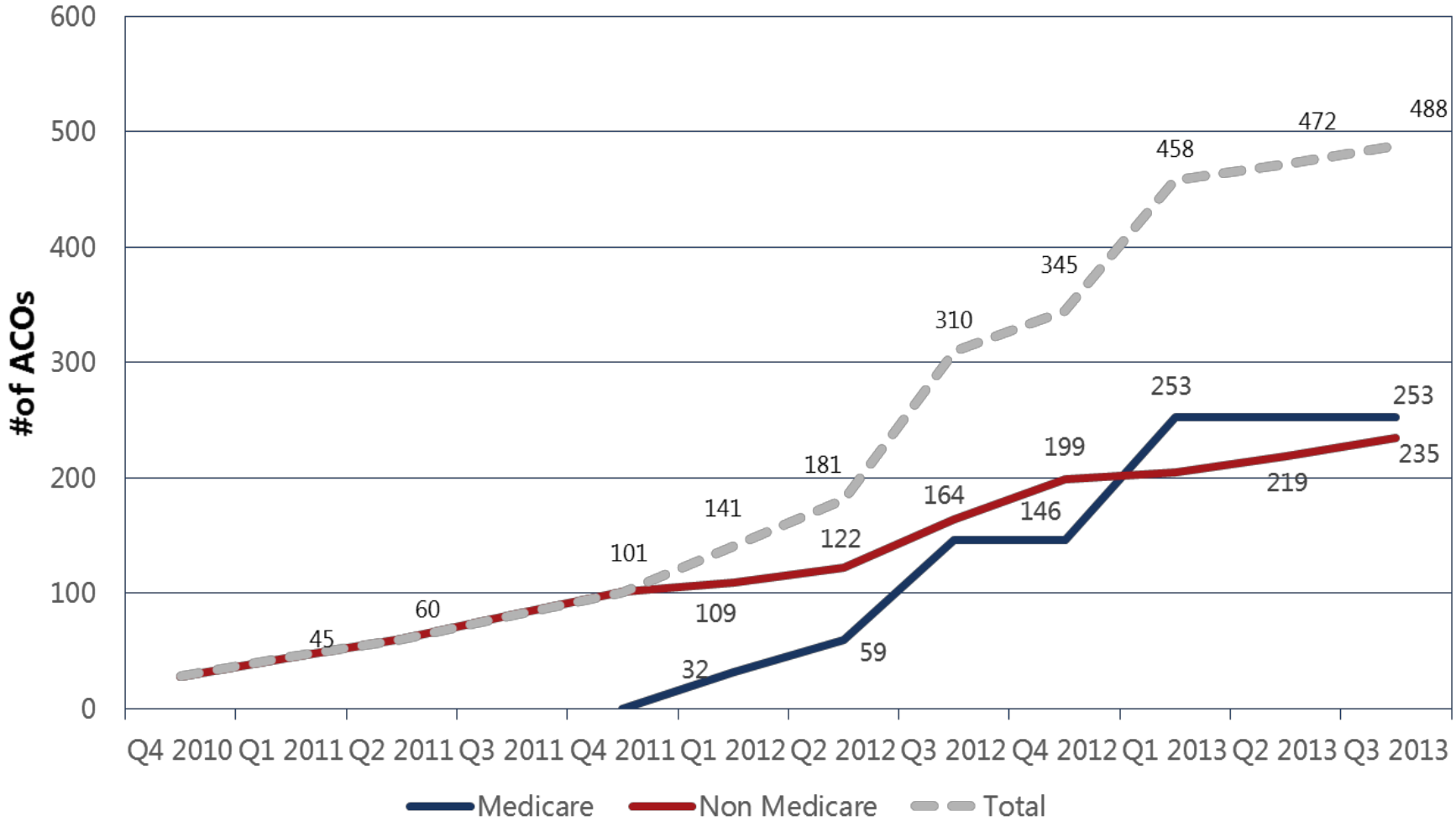
Here's a bold prediction for the new year. By 2020, the American health insurance industry will be extinct. Insurance companies will be replaced by accountable care organizations — groups of doctors, hospitals and other health care providers who come together to provide the full range of medical care for patients.

Already, most insurance companies barely function as insurers. Most non-elderly Americans — or 60 percent of Americans with employer-provided health insurance — work for companies that are self-insured. In these cases it is the employer, not the insurance company, that assumes most of the risk of paying for the medical care of employees and their families. All that insurance companies do is process billing claims.

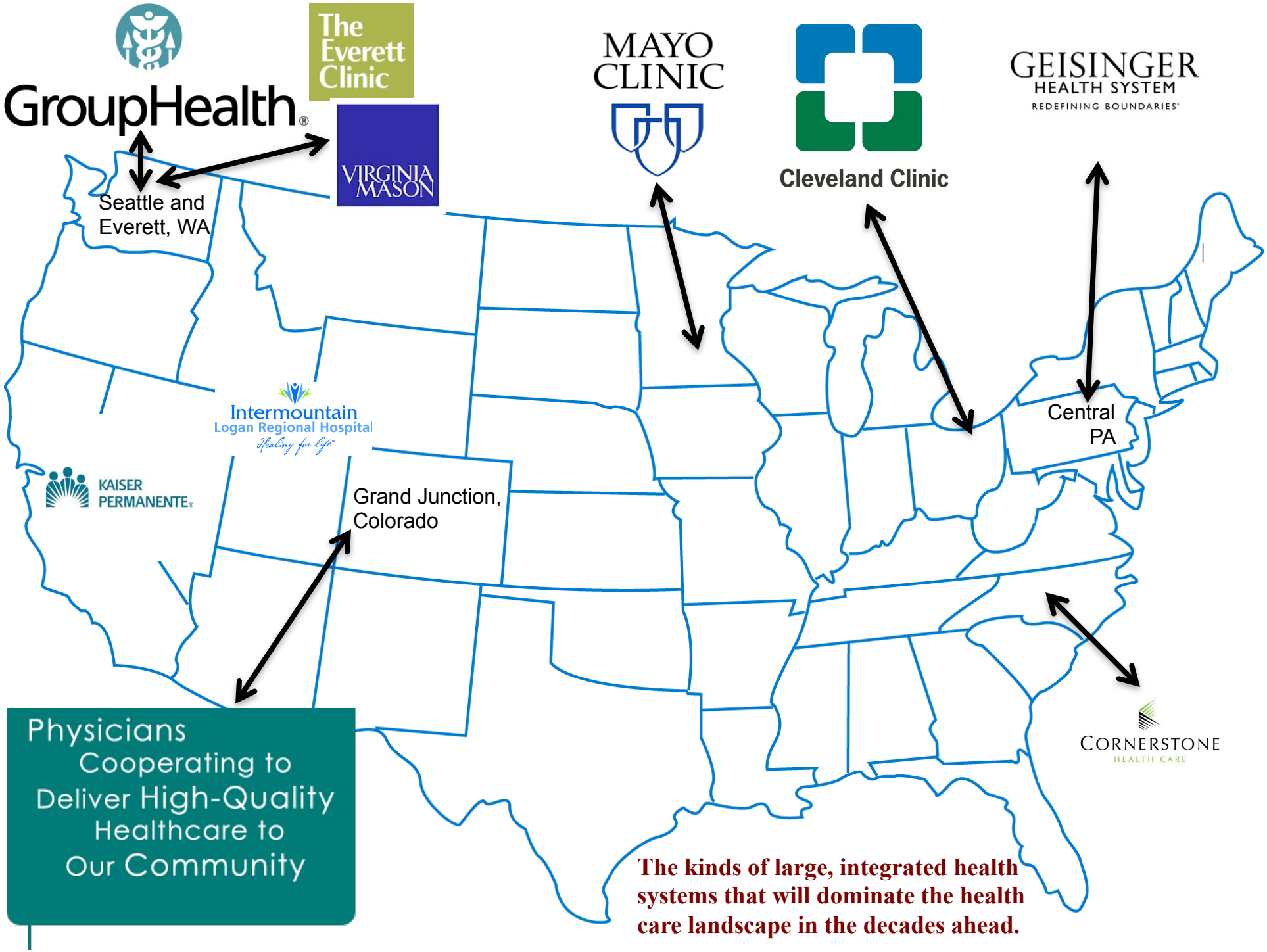


Hospitals are buying out individual physician practices and putting doctors on their payrolls as salaried employees to build larger and larger ACOs and "medical homes". The resulting level of consolidation of health care providers in local communities is both massive and continuing to increase.

Growth of ACOs Over Time
Medicare vs. Non-Medicare



LEAVITT PARTNERS


GroupHealth
The Everett Clinic
VIRGINIA MASON
Seattle and Everett, WA
MAYO CLINIC
Cleveland Clinic
GEISINGER HEALTH SYSTEM
REDEFINING BOUNDARIES
Intermountain
Logan Regional Hospital
Healing for Life
KAISER PERMANENTE
Grand Junction, Colorado
Central PA
CORNERSTONE
HEALTH CARE
Physicians Cooperating to Deliver High-Quality Healthcare to Our Community
The kinds of large, integrated health systems that will dominate the health care landscape in the decades ahead.

Walmart Expands Health Benefits to Cover Heart and Spine Surgeries at No Cost to Associates

Company's New "Centers of Excellence" Program is First-of-its Kind Partnering with Six of the Nation's Foremost Health Care Systems to Provide Better Care

BENTONVILLE, Ark., Oct. 11, 2012 – As health care costs continue to rise, Walmart is introducing a first-of-its-kind Centers of Excellence program that will offer its associates quality health care with no out-of-pocket cost for heart, spine, and transplant surgeries at six of the leading hospital and health systems in the U.S.

The six designated health care organizations include the Cleveland Clinic in Cleveland, Ohio; Geisinger Medical Center in Danville, Pa.; Mayo Clinic sites in Rochester, Minn., Scottsdale/Phoenix, Ariz., and Jacksonville, Fla.; Mercy Hospital Springfield in Springfield, Mo; Scott & White Memorial Hospital in Temple, Texas; and Virginia Mason Medical Center in Seattle, Wash. These organizations will give Walmart associates the opportunity to receive care at hospitals and medical centers geographically located across the country that specialize in heart, spine and transplant care.

Walmart SM

Save money. Live better.

George Halvorson, chairman and chief of Kaiser Permanente, says that the way to get health costs lower is to move care ***farther*** from hospital settings.

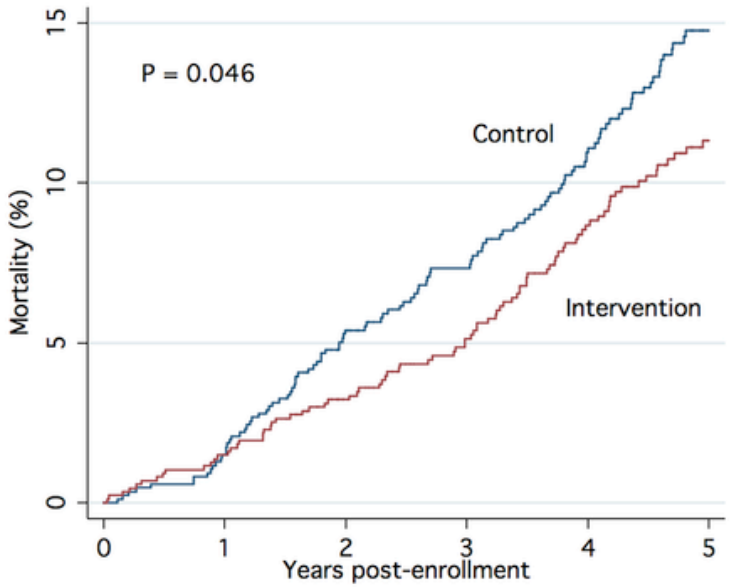
Health Quality Partners (HQP)

EXHIBIT 3

Four Programs' Regression-Adjusted Effects On Medicare Parts A And B Expenditures For One Subgroup Of High-Risk Enrollees, First Six Years

	Health Quality Partners	Hospice of the Valley	Mercy Medical Center	Washington University in St. Louis	Four programs combined
Number of enrollees	273	1,138	904	1,975	4,290
Percent of all program enrollees	16.9	71.3	79.0	71.0	60.1
Statistical power to detect $150 PBPM effect	0.18	0.32	0.59	0.38	0.75
MONTHLY MEDICARE PART A AND B EXPENDITURES					
Without care management fees					
Control-group mean ($)	1,363	2,364	1,366	2,521	2,159
Treatment-control difference ($)	−408	−112	−111	−98	−123
90% CI ($)	−741, −76	−321, 97	−243, 22	−283, 86	−229, −
Percent difference	-30.0	−4.7	−8.1	−3.9	−5.7
p value	0.045	0.38	0.17	0.38	0.057
With care management fees					
Treatment-control difference ($)	−293	66	131	61	55
90% CI ($)	−626, 40	−143, 274	−1, 263	−123, 246	−51, 16
Percent difference	−21.5	2.8	9.6	2.4	2.6
p value	0.15	0.61	0.10	0.59	0.39

SOURCE Authors' calculations based on data from Medicare Enrollment Database, National Claims History File, and Standa File. **NOTES** *High risk* was defined as patients who, at the time of enrollment, met the criteria for the fourth subgroup in Exhil is per beneficiary per month. CI is confidence interval.



Number at Risk (Deaths)

Control 863 (13) 850 (33) 766 (15) 712 (27) 617 (23) 398

Intervention 873 (13) 860 (15) 792 (15) 738 (27) 642 (16) 417

III. The "Storm" of Change is Growing…

- Some of the anger over "Obamacare" is fear on the part of current stakeholders of the market-driven reforms that the ACA is accelerating.

- With almost 500 ACOs operating in 48 states and more on the way, health care increasingly will be delivered by larger (yet fewer) provider organizations.

- Medicare is the federal government's primary vehicle for driving major changes in the finance, organization and delivery of health care for everyone (not just Medicare beneficiaries)