

Teasing Sanity from Insanity

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Objectives

- Explain some of the forces driving current health care dysfunction - - - how we got here
- What this dysfunction has led to - that many of you must deal with daily
- Changes occurring to create an improved and less dysfunctional system?
- What new and innovative technology may provide
- What court rulings may do to change health care

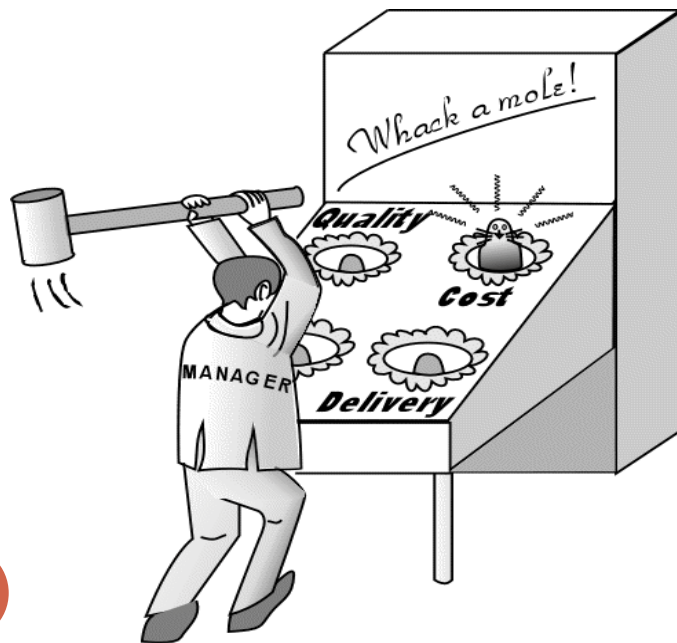
Where to start?

When one begins to think about dysfunction (insanity) in the health care system, the hardest part may be deciding where to start.

Bernie Emkes - 2013

Bernie's Definition of Health Care

Health care is nothing more than one big
Whack-a-Mole game.



Bernie Emkes MD –
2012

Let the Games Begin

- Patients have many issues in accessing and then properly utilizing health care resources
 - Wrong place – wrong time
- Disparities exist
 - Poverty
 - Transportation and schedules
 - Ethnic and cultural variations
- Social issues get in the way of good health and obtaining good health care

An Insane World Called Health Care

- No one can truly understand health care prices, what is owed or how to comparison shop
 - Charges very much unrelated to payments
- Many vested interests at odds with each other
 - Employers, health plans or TPA's, hospitals, doctors - who is actually working for the patient?
- Multiple sets of rules / guidelines
 - Choosing the right guideline from the right set
 - Inconsistent interpretation of the guidelines
- Payer policies regarding non-coverage
- Summary Plan Descriptions

Health Care 2013

*Toto, I've a feeling we are not in
Kansas anymore.*



Dorothy – Wizard of Oz

What Has Driven The Confusion?

- Screening PSA ---- or NOT?
 - Chasing minor abnormalities may be useless and costly
- Too many pelvic exams?
 - Incidental findings and follow up stressful and costly
- Is elevated cholesterol really the cause of heart disease?
 - Are other factors equally to blame?
- How often should mammograms be done?
 - Yearly – every two years – age 40?

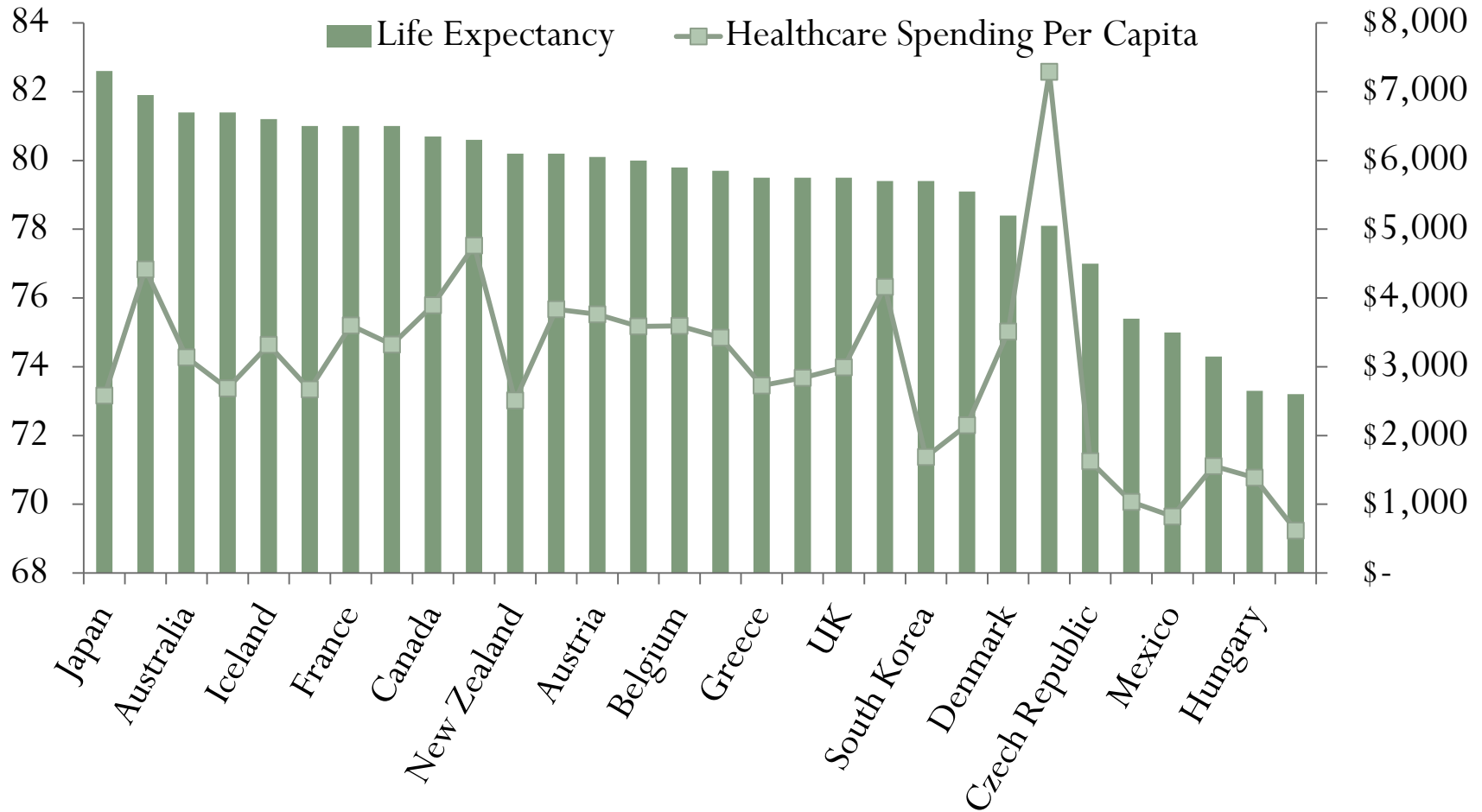
It's No Wonder

- Employers and payers are confused about what is “best care”, “best practice” or “evidence – based care”
- We cannot even decide among ourselves what is correct
 - If we cannot accurately guide non-clinical persons to decide what they need to do, how can we expect them to behave other than insanely?
 - For what services should an employer pay?
 - Leads to - - Prior Auth for MANY services
 - This leaves all kinds of opportunities to mis-define coverage and payment policies

What is the Issue?

- If health care costs were low, this would not be as significant a discussion
 - But health care costs are HIGH in the USA; nearly twice as high per person than closest other country
 - And little to show for high costs
 - No where near highest life expectancy
 - Infant mortality rates high – especially in certain ethnic groups
 - Disparity of insurance coverage between working “with health care benefits” and others

HEALTHCARE SPENDING PER CAPITA & LIFE EXPECTANCY



Demand for Change

- Employers and government still pay most of the health care bills today
 - Large self-insured companies – ERISA
 - Use TPA – Anthem, UHC, Cigna, Aetna, and “other”
 - Employer can define benefits – do not have to align with normal or even state mandated benefit plans
 - Autism coverage not the same – ABA Therapy
 - Medicare – Traditional and Tricare
 - Medicare Advantage programs that act more like commercial insurance plans
 - Medicaid
 - Federal Employee Health Plan
 - Exchange products – Oct 1, 2013

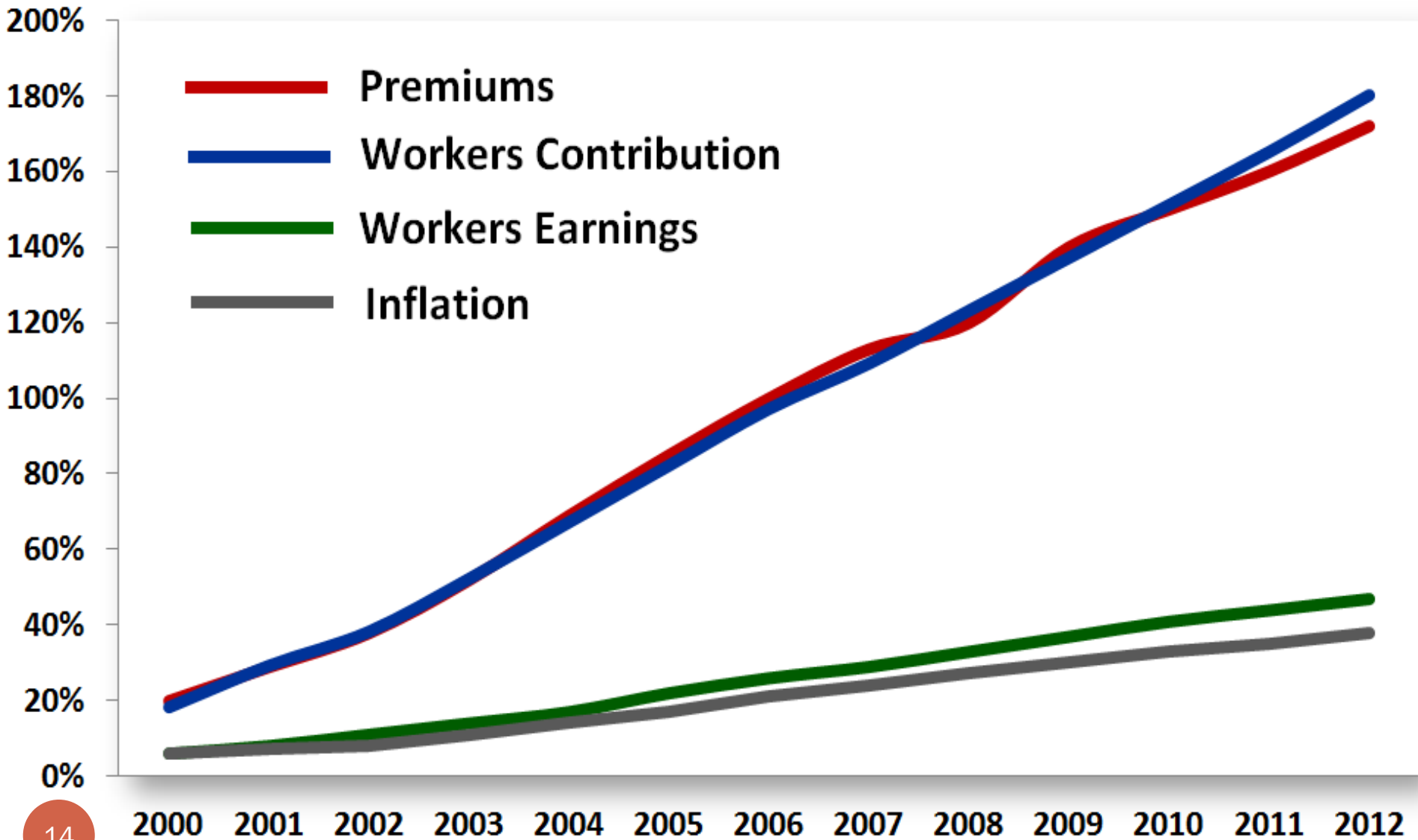
Demand for Change

- The single most important factor driving demand for change is this:

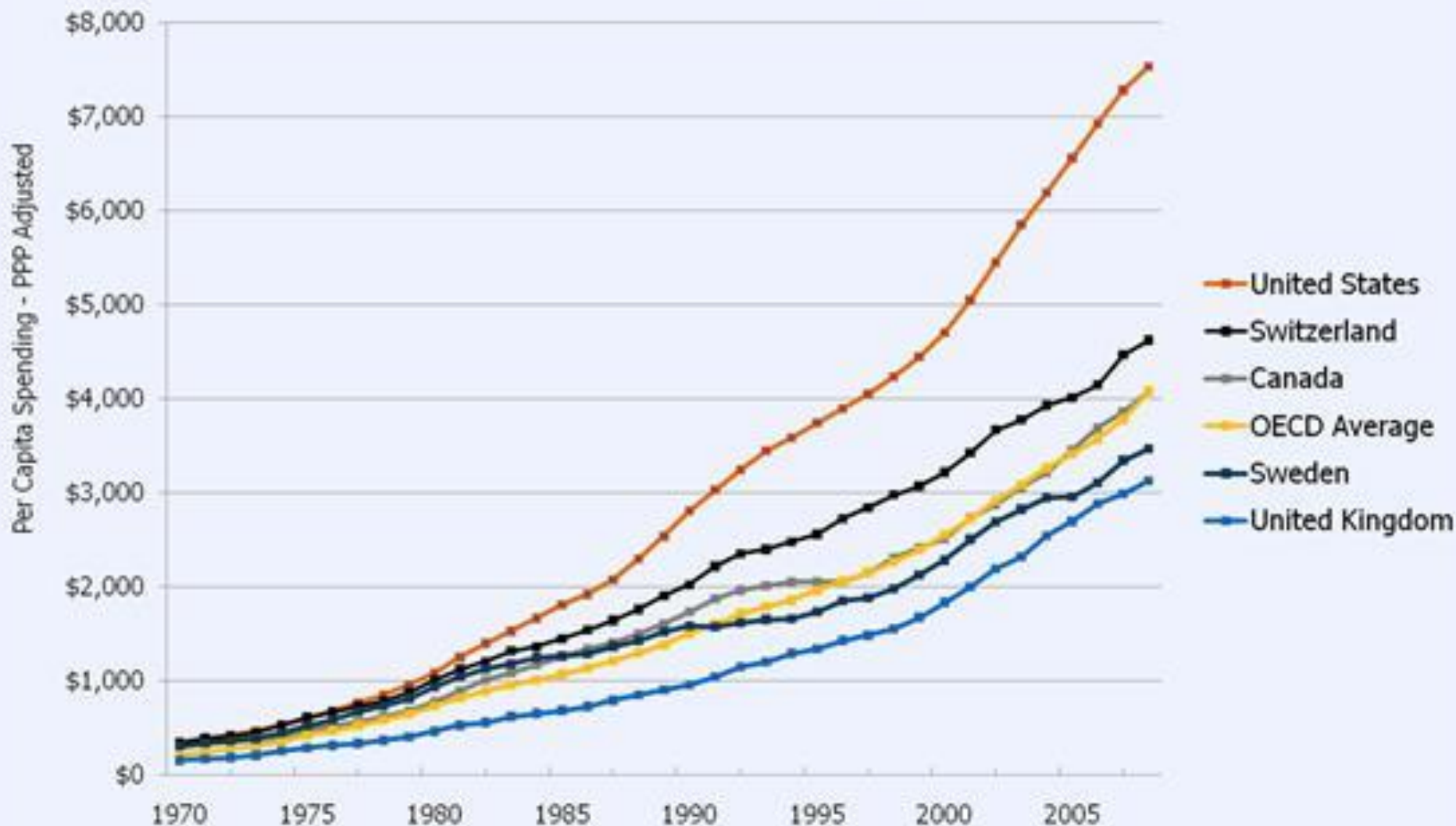
THERE IS NO ONE LEFT TO COST SHIFT TO !

- Patients are being asked to contribute more and more to the expensive costs of their own health care
 - As patients understand the “real costs” of the care someone else has paid for previously, they now are more vested and demand more value

% Increases in Health Insurance Premiums



Growth in Total Health Expenditure Per Capita, U.S. and Selected Countries, 1970-2008



Source: Organisation for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics* (database). doi: 10.1787/data-00350- (accessed on 14 February 2011).

Data from Australia and Japan are 2007 data. Figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted. Break in series: CAN(1995); SWE(1993, 2001); SWI(1995); UK (1997). Numbers are PPP adjusted. Estimates for Canada and Switzerland in 2008.



Rallying Cry 2013 and Beyond

- VALUE – $V = Q/C$
 - What am I getting for what I am paying
 - In the USA – we do not have the longest life expectancy, or the best outcomes; yet we have the highest costs BY FAR in the world
- EFFICIENCY
 - It is no longer good enough to be GOOD
 - Must also be **EFFICIENT**
 - Doctors and hospitals are being profiled
 - Web sites allow enrollees to search for efficient docs
 - As pts have more skin in the game – will increase

We Want More Value !!!

- But what is value?
 - Value to some does not equal value to others
- To some easy and timely access and a doctor they can speak with in order to “partner” on care decisions
- To others very cost effective care
 - Patch me up – get me by
- Skill and a caring attitude – or paternalistic treatment?
 - No one physician can meet every patient need

Cost – The Key Variable

- Most feel 15-20% of costs need to be removed from the current health care system
 - Dan Evans – IU Health CEO – In the IBJ - \$1 BILLION dollars of cost reduction
 - Community Health Network – \$300 million of cost reductions
 - St Vincent Health – Mandates from national – Ascension Health - to make drastic cuts in costs
 - Franciscan Alliance – ACO to contain costs
 - Every level from highest administration down
 - Flattening reporting structure

Cost – The Key Variable

- Health plans already removing “costs” by many means
 - Failure to get a prior auth
 - Claim denials
 - Under-payments
 - Experimental / investigational – black box
 - Audits
 - Take - backs
 - RAC denials of Medicare claims
 - Deferrals to less expensive sites for certain care

What Patients' Want – Ideal State

- Access to health care services on my schedule, at a convenient location, at a reasonable and affordable price with little or no waiting
- Have the primary care offices of 2013 met this challenge?
 - No!
 - 8AM -5PM (or less) hours open – rarely open weekends
 - On site at office only – inconvenient
 - No open appointments
 - Difficult to make appointment – even if available

Consequences

- *Nature abhors a vacuum*
- Corollary – *Human nature dictates that there will be expansion to fill whatever void exists*
- The vacuum is doctors' offices with no open appointments when a patient needs one, as well as limited access hours and no flexibility
- Patient care then expands into whatever is available
 - Walk-in clinics, urgent care, emergency room

We Can Be Our Own Worst Enemies

- Physicians - By not meeting patient needs have:
 - Brought upon themselves many predictable changes in the system
 - Opened the door for new competition
 - Given up a lot of services to non-traditional market players
- Hospitals - By charge manipulation, providing charity care and cost-shifting have:
 - Opened the door to for-profit competitors
 - Given away some of their most profitable business

Access to New Health Venues

- Examples
 - Wal-Mart – 3000 clinics soon
 - CVS – *Minute Clinics* – 650 open
 - Walgreen's – *Take Care Clinics* – 350
 - Now to care for chronic conditions and NOT just sore throats and URI's
 - Is this the ideal model?
 - Free-standing low-cost radiology sites – CDI – Proscan
 - Free-standing ERs – soon to be 51 in Houston
 - Rehab services on every corner with new vendors entering the market regularly -- Select (10), ATI (36) Accelerated (19)
 - Lab services on the free market - Example

Landscape Changes - Costs

- Home monitoring programs
 - Telehealth – in home visits
 - Interactive two-way A/V visits with care coordinators
 - Awesome technology and two-way face-to-face care using Cisco, AT&T and small start-up companies
 - Team approach to care
- Integrated data systems for more efficient long term care
 - Fewer repeat tests
 - Just in time access to the right information when medical decisions need to be made – more later

Landscape Changes - Engagement

- Patient engagement essential
 - Never been required – still not required by Affordable Care Act (ACA)
 - Individual loyalty based on satisfaction with system
 - Population management to help people better afford health care services
 - Actively engaged people have lower HC costs
 - Technology and information can drive better outcomes
 - Requires imagination
 - Lots of work and thoughtful spending

Landscape Changes - Engagement

- Patient engagement continued
 - High value – efficient care
 - Patient-centered medical home concept
 - Physician directed
 - Staff performing at “top of license”
 - Team-based care
 - Community Health Workers to outreach and provide certain services at the most convenient site – patient home
 - Requires access to patient data and information – no more silos of information
 - Integrated care with consideration for socio-economic issues

Landscape Changes - Technology

- New options for health care
 - Castlight Health transparency tool (and others)
 - Smart phone as an EKG machine (FDA approved)
 - Cardiac echo from a Smart phone
 - Continuous blood sugar monitoring – non-invasive from a Smart phone
 - Micro sensors in blood stream to detect arterial wall breakdown products (vulnerable plaque) PRIOR to a heart attack occurring
 - A “heart attack” cell phone call with special ring tone
 - August 2013 – Scripps I-Phone app clinical trial

Landscape Changes - Legal

- Legal rulings impacting health care
 - Human genes cannot be patented
 - No more “brand only” patented testing at exorbitant rates (\$3500 or more for BRCA 1, BRCA 2 tests)
 - Women may soon be tested cost effectively to check for cancer predisposition?
 - Pharmaceutical companies can no longer “buy off” generic companies to prevent generic drugs from reaching the market
 - Law suits will follow suing those who did so in the past

Contracting Changes

- Payment increases tied to performance
 - Anthem already has quality measures for hospitals
 - New MD program 2014 – Patient Centered Primary Care
 - Replaces existing – Quality Health First
 - Humana, United Health Care and others also
- Formula and criteria set on payer end
 - Value not volume is to be paid going forward
 - Payers will increase reimbursement rates, but providers will have to earn some portion or all of that increase
 - No longer CPI PLUS something
 - Lucky to get CPI increases from Medicare as well as commercial payers

Summary

- Warp speed changes over the next 2-3 years
- The convergence of inexpensive technology – (Smart phone) with wireless transmission and microchip development (miniaturization) will lead to never-before-seen advances in health care monitoring as well as transparency
- In 10 years, when we look back on 2013, we will wonder how health care ever became so dysfunctional and inefficient
- By then some of the insanity may be sane

Summary

- If sanity replaces insanity, are there consequences?
- Consistent policies among payers would lead to less dysfunction – therefore less staff to fight the insanity
 - *The Coming Tsunami of Health Care Unemployment*
- Paying for quality makes sense – to a point
- Eventual single payer system?
- Technology advances makes real-time data available at the point-of-care and may avoid improper or ineffective treatments – lowering costs

Hang On – What a Fun Ride !!

- QUESTIONS



- QUESTIONS

