HEALTH CARE REFORM (HCR)
The Providers’ Perspective

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Chairman, California Association of Physician Groups (CAPG)
Chairman, Physician Groups for Coordinated Care (PGCC)
Monarch HealthCare Profile

- Orange County based Independent Practice Accountable Care Organization (IPA)
- Owned and operated by physicians since 1994
- 165,000 beneficiaries cared for under concurrent payment methodology (capitation)
- ~2,300 office based physicians (750 PCPs)
- 17 primary hospital relationships
- All major HMO and many PPO contracts
  - Proprietary Knox-Keene Licensed Senior Plan
HCR: The Providers’ Perspective...
The allergists voted to scratch it, and the dermatologists advised not to make any rash moves.

The gastroenterologists had sort of a gut feeling about it, but the neurologists thought the administration had a lot of nerve, and the obstetricians felt they were all laboring under a misconception.

The ophthalmologists considered the idea shortsighted; the pathologists yelled, "Over my dead body!" while the pediatricians said, "Oh, grow up!"

The psychiatrists thought the whole idea was madness, the radiologists could see right through it, and the surgeons decided to wash their hands of the whole thing. The internists thought it was a bitter pill to swallow, and the plastic surgeons said, "This puts a whole new face on the matter."

The podiatrists thought it was a step forward, but the urologists felt the scheme wouldn't hold water.

The anesthesiologists thought the whole idea was a gas; and the cardiologists didn't have the heart to say no.

In the end, the proctologists left the decision up to the a-holes in Washington....
Today’s Agenda

• HCR – Why bother?
• Most salient elements
  • Political
  • Financial
  • Insurance reform
  • Delivery system
• Will anything be accomplished this time around?
Why Bother?

• Healthcare will cost $2.6 trillion in 2009
  • By 2020, healthcare spending will reach $4.35 trillion

• Healthcare share of GDP increased from 16.6% in 2008 to 17.6% in 2009 (largest one-year jump ever)
  • Medicare hospital fund will begin paying more than it receives this year, and be insolvent by 2017

• 78 million baby boomers beginning 2011
• Uninsured approaching 50 million
The $2,600,000,000,000 Problem

WASTEFUL SPENDING IN U.S. HEALTH CARE
$210 billion - defensive medicine
$210 billion - inefficiencies in care delivery
$100 billion - care for preventable conditions
Halloween Hobgoblins:
The Devil We Know and The Devil We Don’t Know

"I miss the good old days when all we had to fear was fear itself."
Cost of Doing Nothing
The Devil We Know...

- Number of Uninsured Could Reach 66 million in 10 years
- Individual and family health care costs dramatically increase
- Businesses could see health care costs double in 10 years
- Spending on government insurance programs could double
- Uncompensated care in the health system would skyrocket

Without reform, premiums could increase from $13,375 in 2008 to $28,530 in 2019 *

* It was $5,791 in 1999
The Republican Healthcare Plan

EAT ONE DAILY
“The time has arrived…”

The President of the United States stood before Congress and proclaimed that it was time to guarantee healthcare to every American:

“Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.”

President Harry Truman, 1945
History of HCR – Early Efforts

• In 1934, Roosevelt included national health insurance in original Social Security Act
  • AMA mobilized to stop it
  • Fearing defeat, Roosevelt removed it

• During WW-II, government mandated wage and price controls, but exempted fringe benefits
  • Employers offered generous health coverage to attract scarce workers

• In 1946 and 1948 AMA again successfully spear-headed efforts to kill Truman’s national insurance bills
History of HCR
The Saga Continues

- During the 1960s public support grew for a government program for the elderly
  - Over AMA opposition, Kennedy and Johnson successfully created Medicare and Medicaid programs in 1965
  - Largest coverage expansion in American history
  - Supported private insurance industry
  - Encouraged expansion of low-cost insurance options
- In Sept. 1993, Pres. Clinton presented comprehensive HCR plan to Congress
  - 1,342 pages resulting from secret deliberations
  - HIAA “Harry and Louise” ads solidified public opposition
National Healthcare Expenditures as % of Gross Domestic Product (GDP)
Political Issues:
Who’s in Control of the HCR in DC?

- Obama, Rahm Emanuel, Pelosi, Reid, Baucus, Waxman, Rangel, Stark, etc...
- What’s their unifying characteristic?

They’re all Democrats!
Why Is That Important?

• Because payback is a ...

• Can they unite?
  • Progressives
  • Blue Dogs

• Yes...
  • They know they MUST deliver “HCR”!
    (Although others may call it something else)
Goals of Current HCR Efforts

• First (and foremost) - **Cost trend abatement!**
  • Healthcare inflation vs. COL/wage trends
  • Atul Gawande, “The Cost Conundrum”
• Second – Access for all
  • Approaching 50 million uninsured
• Third – Documentable quality outcomes
  • Wennberg, et al – Dartmouth Atlas
Most Salient Elements of Current Proposals

- Reform issues
  - Financial
  - Insurance
  - Delivery system
Republican “Patient’s Choice Act”

- Focus on the 5 preventable chronic conditions that consume 75% of spending
- Create state-based exchanges
- Move tax-deduction from companies to individuals to create portability of coverage
- Move Medicaid patients into private plans with premium subsidies
- Add tort-reforms to decrease defensive medicine
Republican Proposal
Continued...

• Create health record banks with swipe card technology
• Create a Healthcare Services Commission to operate like the SEC and set quality, effectiveness and price transparency standards
Financial Issues
Financial Issues

House Bill (HR 3200)
- Costs $1.04 Trillion/10 yr
- Financing
  - Half from CMS cuts
  - About $156 Billion from MA
  - Half from high income surtax
- Fixes physician SGR issue
  - Costs $228 Billion/10 yr

Senate Finance Committee
- Costs $856 Billion/10 yr
- Financing
  - Half from CMS cuts
  - About $117 Billion from MA
  - Half from industry “fees”
    - Annual insurer fee
    - 35% Cadillac plan tax
- Address SGR for one yr
  - Kicks the can down the road
“Opposing view: Don’t penalize seniors”

• “Yes, Advantage’s costs need to be reined in, but let’s do it gradually.”

• “The debate over Medicare Advantage misses a key point. It's not so much the extras, such as gym memberships, vision and dental care, that drew more than 10 million seniors to the plans. It's the affordable deductibles, co-pays and other such out-of-pocket expenses.”

Bill Nelson (D – FL)
USA Today – Sept 2009
CMS to Humana: “Cease and Desist” – Sept 2009

- “CMS Gag Order Contradicts Policy Set by Clinton Administration”
  - “Prohibiting such information would violate basic freedom of speech and other constitutional rights.”
  - President Bill Clinton’s Director of the DHHS’ Center for Health Plans and Providers (July 1997)
# Insurance Reform Issues

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<th><strong>HR 3200</strong></th>
<th><strong>Senate Finance Committee</strong></th>
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<td>Individual Mandate</td>
<td>Yes</td>
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<td>Employer Mandate</td>
<td>Yes</td>
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<td>Insurance Exchange</td>
<td>Yes</td>
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<tr>
<td>- Four benefit tiers</td>
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<tr>
<td>- Subsidies - Yes</td>
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<td>Expands Medicaid - 133%</td>
<td>Yes</td>
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<td>Public Option - Yes</td>
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<td>Insurance regulations</td>
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<tr>
<td>- Guarantee issue</td>
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<tr>
<td>- No pre-existing conditions</td>
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<td>- No rescissions</td>
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<td>- Modified comm. rating</td>
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Why aren't we using the highway?

I don't believe in public options!
Consumer Operated and Oriented Plan (CO-OP)

- CO-OP must be organized as a “non-profit, member corporation under state law”
- CO-OP must not be “an existing organization that provides insurance as of July 16, 2009”
- CO-OP must not be an affiliate or successor of any such organization
- Any profit must be used to lower premiums, improve benefits
- Must not be sponsored by a state, county or local government
Delivery System Issues

• Already included in stimulus bill
  • Comparative Effectiveness – (EBM)
  • HITECH Act – E-connectivity and EHR

• Quality & efficiency improvement
  • Linking payments to outcomes

• Encourage development of new patient care and payment models
  • ACO
  • CMS Innovation Center
  • Payment bundling
  • Strengthen Primary Care
The HITECH Act

• Physicians can earn between $44,000 to $60,000 in extra payments over a five-year period, if they have a records system in place by 2011
  • By 2015, doctors will face a series of escalating cuts in Medicare payments if they lack a records system
• A “meaningful” certified electronic health record qualifies hospitals and physicians for a total of $17.2 billion worth of payments from Medicare and Medicaid
• A qualifying records system must include: clinical decision support and physician order entry, plus the ability to capture healthcare quality data and support the exchange of clinical data with other organizations
Accountable Care Organizations (ACO)

- The ACO is the overarching structure through which key components of reform can succeed:
  - Bundled payments ("capitation")
  - Medical home and care coordination
  - Health IT
  - Strengthening Primary Care

- ACO can provide and manage continuum of care as an integrated delivery system

- ACO has local accountability for cost, quality and access

- ACO has sufficient size to support comprehensive performance measurement
Massachusetts Commonwealth Care

- 3 years into the program 97% are insured but costs are out of control
- State commission has recommended to restructure payments
  - Doctors and hospitals would form networks called accountable care organizations responsible for a patient’s well-being and compensated with a flat monthly payment
- Plan would offer financial incentives for performance that would transform physicians into care coordinators
ACO Provisions

**HR 3200**

- **Shared savings and partial capitation for Medicare FFS pts**
- **Criteria:**
  - Legal structure
  - Adequate numbers of PCP and beneficiaries
  - Capable of reporting quality outcomes
  - Patient-centric care processes
- **Broad discretion to Secr.**

**Senate Finance Committee**

- **Shared savings model for Medicare FFS pts**
- **Criteria:**
  - Minimum 3-yr participation
  - Legal structure to receive and distribute bonuses
  - Include PCP for > 5,000 pts
  - Core group of Specialists
  - EBM and coordinate care
  - Report quality & cost metrics
  - Patient-centeredness
- **Broad discretion to Secr.**
ACO Critical Success Factors: Can the California Model Work Elsewhere?

- Tiered ACO levels based on local capability
- Engage physician leadership with business acumen, and hire business talent
- Develop finance department strength and maintain adequate reserves
- Clinical department must bring value, not merely perform administrative processes
ACO Critical Success Factors: Can the California Model Work Elsewhere?

- Robust investment in IT systems, with data warehouse reporting capability, and an enterprise wide electronic health record
- Align physician incentives through concurrent payment coupled with performance bonuses
- Reduce physician hassle factor and pay physicians in a timely manner
Conclusions:  
Short-Term Implications

• Decreased funding will be a big issue for MA plans and providers
  • Strong will get stronger; the weak will fail
• Gov’t Programs (i.e. Medicaid, CHIP, Medicare, CO-OPs, etc.) will expand
  • Increased coverage & overall spending
  • Increased premiums for commercial plans
    • (Fees, adverse selection, cost-shift burden)
Conclusions: Intermediate-Term Implications

- HCR has become a process, not an event!
  - But, the snowball has started down the hill!
- The contentious political debate will continue
  - Dems will try to expand Gov’t Programs
  - Reps will try to support Private Insurance
- Everyone wants to control HC cost trend!
  - HHS Secretary will launch innovative pilots
  - The nation will begin to move from FFS toward coordinated care (ACO) model
Conclusions:
Long-Term Implications
Questions and Discussion