PRINCETON CONFERENCE

May 20, 2009
FIRST QUESTION

Is Stuart Altman really a Fascist?

The right-wing blogosphere has labeled him thus because he defends cost effectiveness analysis.
STUART, THE COMMIE ProPAC APPARATCHIK
WORKING UNDERCOVER
FINANCING HEALTH SERVICES

Uwe E. Reinhardt,
Princeton University

The 16th Annual Princeton Conference

“How Will We Meet the Health Service Needs of an Aging America?”

May 20-21, 2009
In the United States, we know that most people ultimately rely on Medicare and Medicaid for health services and long term care. Based on current CMS projections, the current financial model is not sustainable. What are the most reasonable options for financial reform? Are bundled payments the way of the future? Can we look to the private sector for help? What has the VA done and can we learn anything from their experience?
I. THE SUSTAINABILITY OF MEDICARE AND MEDICAID
The Long-Term Outlook for Health Care Spending

November, 2007
Figure 4.
Projected Spending on Health Care as a Percentage of Gross Domestic Product

(Percent)

Source: Congressional Budget Office.

Note: Amounts for Medicare are net of beneficiaries' premiums. Amounts for Medicaid are federal spending only.

REAL GDP PER CAPITA 2008 AND 2050 (1% Annual Growth)

- 2008: $47,500
- 2050: $72,200

- Non-Medicare & Medicaid: $47,500
- Medicare & Medicaid: $24,700

(1% Annual Growth)
y = 16575e^{0.0198x} \quad \text{R}^2 = 0.9932

Implies 2% annual growth

SOURCE: CMS Data & Statistics.
REAL GDP PER CAPITA 2008 AND 2050 (1.5% Annual Growth)

<table>
<thead>
<tr>
<th>Year</th>
<th>Non-Medicare &amp; Medicaid</th>
<th>Medicare &amp; Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$47,500</td>
<td></td>
</tr>
<tr>
<td>2050</td>
<td>$88,850</td>
<td></td>
</tr>
</tbody>
</table>
I take it that by “sustainability” we do not mean “economic sustainability” but “political sustainability”, that is, willingness to pay taxes to care for the health care of the elderly.

Or do we mean by “sustainability” that we cannot afford anymore the “overuse, misuse and fraud” we believe is rampant in US health care – for old and young?
Top-Line Findings:
A Substantial Health Care Value Gap

On a weighted scale, U.S. business faces a 23 percent “value gap” relative to five leading industrialized competitors – and a 46 percent “value gap” against three rising economic powers.

• Combining 19 internationally reported measures in a weighted scale that takes into account both the spending on, and performance of, our health care system, the United States stands at a 23 percent disadvantage relative to five leading economic competitors – Canada, Japan, Germany, the United Kingdom and France (the “G-5 group”) – and a 46 percent disadvantage relative to the emerging competitors of Brazil, India and China (the “BIC group”).
PROJECTED U.S. HEALTH SPENDING AS PERCENT OF GDP

Health spending grows 2.5% points faster than the rest of GDP

Health spending grows 1% point faster than the rest of GDP
Secretary of HHS David Petraeus
II. THE FINANCING OF HEALTH CARE
ROAD MAP FOR FINANCING HEALTH CARE

PRIVATE HOUSEHOLDS

TAXES

INSURANCE PREMIUMS

WAGE CUTS

GOVERNMENT

INSURANCE POOLS

EMPLOYERS

PROVIDERS OF CARE

FEE-FOR-SERVICE

CAPITATION

BUNDLED PAYMENTS

BUDGETS

User fees (Out of Pocket Spending)
ROAD MAP FOR FINANCING HEALTH CARE

PRIVATE HOUSEHOLDS

TAXES

GOVERNMENT

INSURANCE PREMIUMS

EMPLOYERS

USER FEES (Out of Pocket Spending)

WAGE CUTS

PROVIDERS OF CARE

FEE-FOR-SERVICE

BUNDELED PAYMENTS

CAPITATION

BUDGETS
III. PAYING THE PROVIDERS OF HEALTH CARE

A. Medicare: the “big dumb price fixer.”
Relative Profitability across DRGs
Cardiac DRGs

Source: MedPAC
III. PAYING THE PROVIDERS OF HEALTH CARE

A. Medicare: the “big dumb price fixer.”

B. Private insurers: Smart price negotiators?
Table 6.3:
Large New Jersey Insurer’s Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers – Minimum Cost Per Procedure versus Maximum Cost Per Procedure

<table>
<thead>
<tr>
<th>Cost per Colonoscopy</th>
<th>In-Network Minimum to Maximum Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>$178 to $431</td>
</tr>
<tr>
<td>Hospital</td>
<td>$716 to $3,717</td>
</tr>
<tr>
<td>ASC</td>
<td>$443 to $1,395</td>
</tr>
</tbody>
</table>
### Table 6.4:
Payments by a N.J. Insurer to Various Hospitals for Four Standards Services, 2007

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Normal Delivery&lt;sup&gt;1&lt;/sup&gt;</th>
<th>CABG&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Appendectomy&lt;sup&gt;3&lt;/sup&gt;</th>
<th>Hip Replacement&lt;sup&gt;4&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>$2,178</td>
<td>$26,342</td>
<td>$2,708</td>
<td>$3,330</td>
</tr>
<tr>
<td>Hospital B</td>
<td>$2,787</td>
<td>$32,127</td>
<td>$2,852</td>
<td>$3,444</td>
</tr>
<tr>
<td>Hospital C</td>
<td>$2,906</td>
<td>$34,277</td>
<td>$3,320</td>
<td>$4,200</td>
</tr>
<tr>
<td>Hospital D</td>
<td>$3,187</td>
<td>$36,792</td>
<td>$3,412</td>
<td>$4,230</td>
</tr>
<tr>
<td>Hospital E</td>
<td>$3,276</td>
<td>$37,019</td>
<td>$3,524</td>
<td>$5,028</td>
</tr>
<tr>
<td>Hospital F</td>
<td>$3,629</td>
<td>$45,343</td>
<td>$4,230</td>
<td>$5,787</td>
</tr>
</tbody>
</table>

<sup>1</sup> Mother only, case rate.

<sup>2</sup> Coronary Bypass with Cardiac Catheterization (DRG 547), tertiary hospitals only.

<sup>3</sup> Surgical per diem (DRG 167) with average length of stay of 2 days

<sup>4</sup> Surgical per diem for Total Hip replacement, average length of stay 3 days.
Table 6.5: Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Appendectomy(^1)</th>
<th>CABG(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>$1,800</td>
<td>$33,000</td>
</tr>
<tr>
<td>Hospital B</td>
<td>$2,900</td>
<td>$54,600</td>
</tr>
<tr>
<td>Hospital C</td>
<td>$4,700</td>
<td>$64,500</td>
</tr>
<tr>
<td>Hospital D</td>
<td>$9,500</td>
<td>$72,300</td>
</tr>
<tr>
<td>Hospital E</td>
<td>$13,700</td>
<td>$99,800</td>
</tr>
</tbody>
</table>

\(^1\) Cost per case (DRG 167)
\(^2\) Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.
III. PAYING THE PROVIDERS OF HEALTH CARE

A. Medicare: the “big dumb price fixer.”

B. Private insurers: Smart price negotiators?

B. The new panacea: Bundled payments
Provider payment Reform for Outcomes Margins Evidence Transparency Hassle-reduction Excellence Understandability and Sustainability
Rummaging through the Prometheus Payment® Inc. website quickly makes it clear that developing Evidence Based Case Reimbursement (ECRs) payments is a technically difficult as well as politically difficult.

Bundled payments are designed to trigger clinical integration of the delivery of care across ambulatory and inpatient sites.

But that implies a redistribution of cherished professional and economic privilege.
EXAMPLE

Bundling radiologists, anesthesiologists and pathologists (the RAPs) as well as convalescent care into the DRG payments to hospitals.

How easy would that be?
III. PAYING THE PROVIDERS OF HEALTH CARE

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B. The new panacea: Bundled payments

C. Clinically Integrated Health Care
FROM A TALK GIVEN 15 YEARS AGO:

HEALTH “SYSTEMS” AS A SET OF SILOS

- AMBULATORY
  - LEGAL
  - ADMIN.
  - ECONOMIC
  - CLINICAL
- INPATIENT
  - LEGAL
  - ADMIN.
  - ECONOMIC
  - CLINICAL
- NURSING HM
  - LEGAL
  - ADMIN.
  - ECONOMIC
  - CLINICAL
- HOME CARE
  - LEGAL
  - ADMIN.
  - ECONOMIC
  - CLINICAL
- OTHER
  - LEGAL
  - ADMIN.
  - ECONOMIC
  - CLINICAL
CONSOLIDATION JUST FOR THE FUN OF IT

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**INTEGRATED LEGAL STRUCTURE**

- ADMIN.
- ECONOMIC
- CLINICAL
- ADMIN.
- ECONOMIC
- CLINICAL
- ADMIN.
- ECONOMIC
- CLINICAL
- ADMIN.
- ECONOMIC
- CLINICAL
- ADMIN.
- ECONOMIC
- CLINICAL
HARVESTING A LITTLE “SYNERGISM”

Firing a few hapless accountants

<table>
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<th>AMBULATORY</th>
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INTEGRATED LEGAL STRUCTURE

INTEGRATED ADMINISTRATIVE STRUCTURE (INCL. ACCOUNTING)

<table>
<thead>
<tr>
<th>ECONOMIC</th>
<th>ECONOMIC</th>
<th>ECONOMIC</th>
<th>ECONOMIC</th>
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</thead>
<tbody>
<tr>
<td>CLINICAL</td>
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</tr>
</tbody>
</table>
HARVESTING MORE SIGNIFICANT “SYNGERISISM”

Eliminating duplicative clinical programs

Creating market muscle (monopoly power)
ATTEMPTING THE REAL McCOY:
Genuine, patient-focused clinical integration

So far this is mainly a blueprint.

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- INTEGRATED LEGAL STRUCTURE
- INTEGRATED ADMINISTRATIVE STRUCTURE (INCL. ACCOUNTING)
- INTEGRATED ECONOMIC STRUCTURE (INCL. MARKETING)
- GENUINE, PATIENT-FOCUSED CLINICAL INTEGRATION
III. PAYING THE PROVIDERS OF HEALTH CARE

A. Medicare: the “big dumb price fixer.”

B. Private insurers: Smart price negotiators?

B. The new panacea: Bundled payments

C. Clinically Integrated Health Care

D. A Modest Proposal
A MODEST PROPOSAL

1. Require that hospitals use the DRG system as a relative value scale for all patients.

2. Allow hospitals to set their own conversion ratios.

3. Require hospitals to charge the same fees to all payers.

4. Start bundling in the RAPs and convalescent care.

5. With most of inpatient care bundled in this way, expand the system to embrace more and more of care in other setting.
If you think this would be politically too difficult, what makes you think imposing bundled payments on the American health system – that collection of separate fiefdoms -- would be any easier?
Mazel tov!