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Health System Reform: Why Now, What Might Happen, and Where Do “Medical Homes” Fit In?

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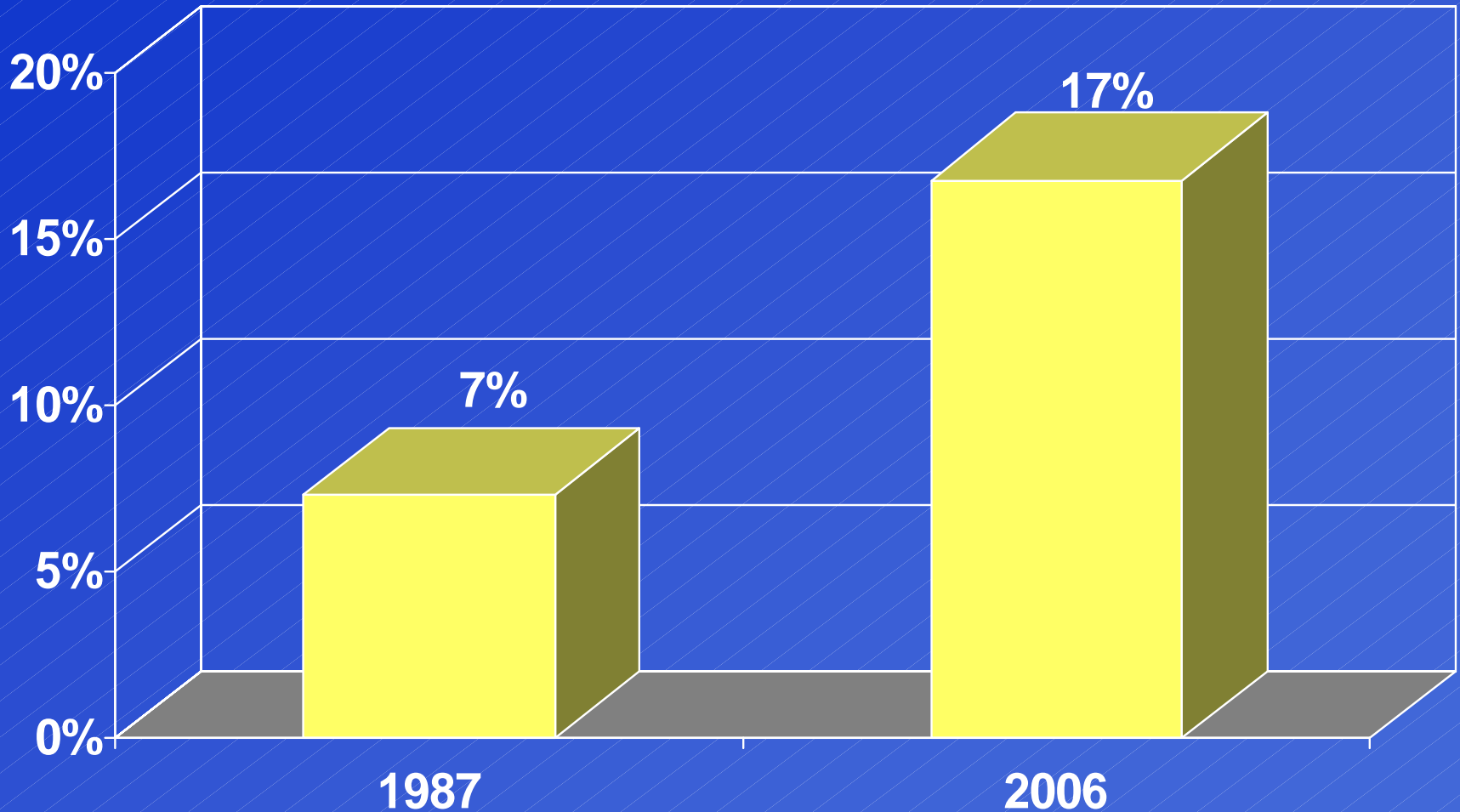
Overview

- Why Now
- Competing Visions
- 2008 Presidential Candidates, then and now
- Congressional groundwork for 2009-2010
- Common Elements
- What's Next?

Why NOW?

- Premium / income is higher and growing

Percent of median family income required to buy family health insurance



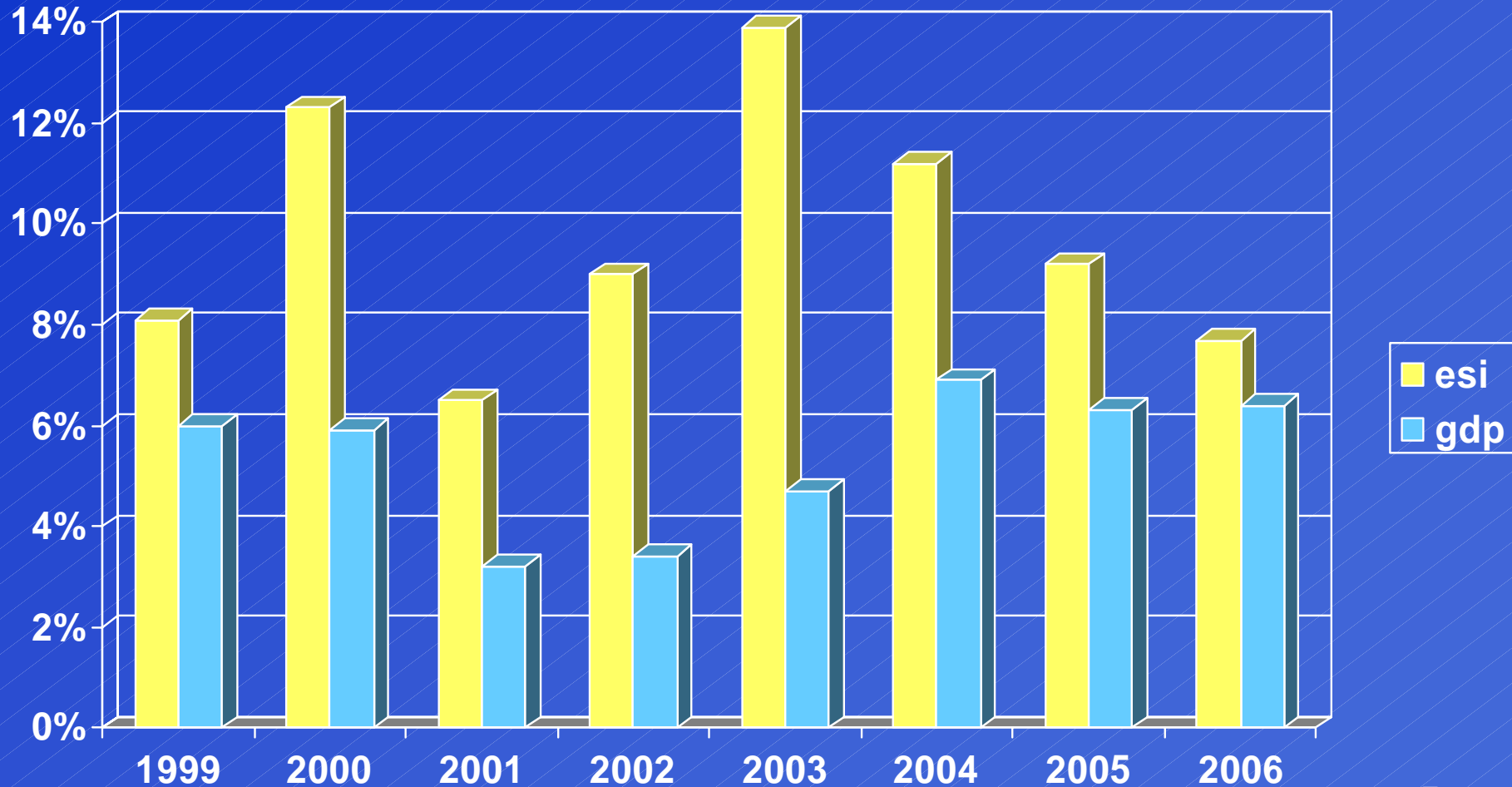
Why NOW?

- Premium / income is higher and growing
- International competition is more pervasive

Employer Contribution Rates and Hourly Cost of Health Benefits, Selected Top Trading Partners

Country (rank in total trade with the US, 2005)	Employer Contribution Rate	Hourly Pay, Manufacturing U.S. dollars	Hourly Cost of Health Benefits, Manufacturing US dollars
United States	11.3%		
	13.0% for Manufacturing	\$18.32	\$2.38
Canada (1)	4.5%*	\$19.21	\$0.86
Japan (4)	3.74%	\$18.06	\$0.68
Germany (5)	6.65%**	\$25.53	\$1.70
United Kingdom (6)	1.92%***	\$20.91	\$0.40
France (9)	12.8%****	\$16.93	\$2.17
Weighted avg.	4.9%	\$19.79	\$0.96

Premium Payments v. GDP Growth Rate



Why NOW?

- Premium / income is higher and growing
- International competition is more threatening
- More awareness of LINKAGES among problems
 - costs of spotty quality
 - consequences of being uninsured
- System stresses appear more unsustainable to more people
 - ER waits + diversions, generalized access problems
 - Cost-shifting from “hidden tax” part of low value per dollar

Competing Visions

- Each Man for Himself – Individualism
 - Consumer-centric
 - Tax neutrality
 - Individual market
 - NO regulations (or Shadegg-DeMint, which is the same thing)
- Government for all – Socialism
 - Equity-centric
 - Government sole payer
 - Population health management
- Practical Idealism – Realism
 - Result-centric (cover all in *sustainable* system)
 - Markets are powerful but flawed and need smart regulation)
 - Purchase requirements make markets work better
 - Electronic information system, comparative effectiveness , re-aligned incentives are keys to Efficiency and Justice

The Good News

- Dems have discovered markets and the importance of value enhancement/cost-growth control
 - Modal proposal had regulated private insurance markets, purchase requirements*
 - Emphasize delivery system reform through information systems and comparative effectiveness, some payment reforms
- Repubs have acknowledged that many cannot afford health insurance as we know it
- McCain discovered supply-side incentives are important, too
- Huckabee stressed behavioral change
- Romney created and “owned” Massachusetts reform model

Meanwhile, Back in Washington...

- Massachusetts and California got noticed
- “Strange” coalitions formed in 2007
 - BHCT, Divided We Fail
- Vision of many trade groups remarkably similar to modal Dem proposal
 - FAH, ERIC, CED, Advamed (save Comp. Effectiveness)
- Wyden-Bennett (S. 334) has 14 co-sponsors
 - Bennett, Gregg, Grassley, Alexander, Coleman, Crapo, Corker
 - Wyden, Nelson (FL), Stabenow, Lieberman, Carper, Landrieu, Inoyue
 - Has mandate, new markets, subsidies, phases down employer financing, uses existing tax \$
 - Emphasizes delivery system reform as well
 - “Health Home,” FDA reform, etc.
- At least 3 other bi-partisan conversations in House
 - Baird-Emerson, Langevin-Shays, Cooper-Castle

Common Themes To Expect

- We Cannot Afford It (whatever “IT” is)
- Trust, but Verify
 - Transparency of price and comparative quality info
 - Market outcomes will need to be monitored
 - Government programs will need to be evaluated
- Shared Responsibility *is* the American Way
 - Individual responsibility is central
 - Community responsibility is to make it possible for each individual to take responsibility for himself or herself
 - Part of shared responsibility is making system sustainable, i.e., stewardship
- Cost of doing nothing is high

Cost Growth Matters Because...

- Opportunity Cost
 - Crowding out other priorities
 - Households
 - Employers
 - Governments
 - System stakeholders
- We are not willing to cover everyone with current system trajectories
- We must cover everyone, or risk yet more social segmentation

Capturing Savings from Delivery System Reform

- Good Idea
- It will be hard
 - One person's cost is another's income
 - "Excess" cost is income too
 - Business case for savings weak for many providers
- It will take time
 - Cost-shifts have multiple participants, time horizons
- It must be sought
 - We simply cannot afford current trajectories, period

Incentive Mis-Alignment

- Fee-for-service for providers + low-cost sharing for most patients + small effective evidence base => too much low value/redundant care
 - Share savings from smarter care with providers and patients
 - Set bundled payment at “efficient” level
- Technology “approval” = ticket to market
 - Beating placebo \neq adding clinical value
 - Raise approval bar in exchange for longer period of exclusivity
 - Set cost-sharing according to value added

Promising Examples

- Medical Home in NC Medicaid
 - Community Care North Carolina
 - Paid MDs and care management network \$3 pmpm each
 - Focus on chronic disease management
 - Saved 3% of total Medicaid spending, 11% of state Medicaid spending, from '04-06 (mercer) and “educators”
 - Savings from creating space for care management, not shared savings incentives

Promising Examples

- Sumner Clinic in Gallatin, Tennessee
 - Protocols plus nurse care coordinator
 - But sans payment reform, would turn savings over to Medicare
 - Struck incentive deal with MA plan (HealthSpring)
 - All quality measures exceeded 90%
 - ER down 23%
 - Admissions down 16%
 - Loss ratio fell from 87% to 77%, now down to 69%
 - Quality, income, and profits up, costs down

Promising Examples

- Intermountain Health Care using information and protocols
 - Brent James studied variations within LDS hospital
 - Shared info, let specialists develop own protocols
 - Care improved, savings achieved
 - Much turned back to Medicare, health plan created/expanded to help capture savings

Source: Guy Clifton, *Flatlined: the Resuscitation of American Medicine*, Rutgers Press: (forthcoming 2008)

Promising Examples

- Virtual Group (Hill, an IPA) using info system and “health educators”
- “Never Event” approach of Medicare, Pennsylvania, Geisinger, Mayo
- Generic use up to 57% of scripts
- Shared savings payment reform ideas of COPE

Vision

- Electronic information infrastructure
 - eHRs, decision support, data exchanges for care coordination and research base
- Incentive re-alignment
 - Shared savings with providers
 - Evidence-based cost-sharing
 - Malpractice reform
- Comparative Effectiveness Infrastructure
 - Turbo-charge production of evidence base
 - Incentive re-alignment plus information turbocharges drive toward efficiency in all things, allows bureaucracies to stop back
- Some/most/all of cost of coverage expansion can be financed this way in the long run (1.5T over 10 years, per CMWF and Lewin)

Who Will Win?

- Those who can produce value and verify contributions to sophisticated buyers *and* to patients
- Those who are better at science than marketing
 - Patients' agents will set coverage, payment, and cost-sharing policies
 - McCain vs. Dems on who will be the agents?

Who Will Be the Agents?

- McCain
 - Individuals (reduce employer role, regulation)
 - Emphasize individual insurance market
 - Government can require transparency + Medicare payment reform
- Dems
 - HIT + Comparative effectiveness institute
 - Emphasize GROUP purchasing, exchange, RFPs including incentives for “health homes”
 - Payment reform throughout system