HealthCare Reforms
What the future holds

by Robert E. Goff
The future belongs to those who prepare for it today.

- Malcolm X
The Uncomfortable Reality
That scares anyone that understands it
KEEP CALM AND TAKE NOTES
The president yesterday finally admitted what everyone in America already knew: ObamaCare is a total and unmitigated DISASTER.

THE EMPLOYER MANDATE PART IS ON BACKORDER... SHOULD HAVE IT BY 2015...

THEM: I can't read the small print.
ME: GOOD.

OBAMA: Look, Daddy. Every time a bell rings an American loses his health insurance.
Health Reform Has Been Happening

- Small business tax credit
- Prohibitions against lifetime benefit caps & rescissions
- Phased-in ban on annual limits
- Annual review of premium increases
- Public reporting by insurers on share of premiums spent on non-medical costs
- Preventive services coverage without cost-sharing
- Young adults on parents’ plans

- States adopt exchange legislation and begin implementing exchanges
- Phased-in ban on annual limits
- Insurers must spend at least 85% of premiums (large group) or 80% (small group / individual) on medical costs or provide rebates to enrollees
- HHS must determine if states will have operational exchanges by 2014; if not, HHS will operate them

- State Insurance Exchanges
- Medicaid expansion
- Small business tax credit increases
- Insurance market reforms including no rating on health
- Essential benefit standard
- Individual requirement to have insurance
- Employer shared responsibility penalties

- Penalty for individual requirement to have insurance phases in (2014-2016)
- Option for state waiver to design alternative coverage programs (2017)
- Employer mandate kicks in 2015
In 2011 Health Insurance Companies Became Public Utilities

• Insurers must spend on medical expenses at least
• 85% of premiums (large group) or
• 80% (small group/individual)
• Or provide rebates to enrollees

• Premium increases subject to state rate review and approval
Health Plans worst possible position

- Public Policy demands premium “restraint”
- If there is a surplus – must refund it
- If there is a deficient – must absorb it
- Better to have a surplus than a loss

- Cost of care controls
  - Deductibles
  - Narrow Networks
  - Ending OON
  - Rate restraint

- Try to grow revue outside of insurance
  - Optum/United
  - Aetna – WellMatch
Impact on physician

**Narrow Network**
- In - loss of income
- Out – loss of volume
- The virtual end of OON Coverage

**Deductibles**
- Dramatically restrain care
- Patients seek alternative care sources during deductible period
- Increasing receivables
Damn the deductibles

<table>
<thead>
<tr>
<th>Exchange Deductibles</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platinum</td>
<td>-0-</td>
<td></td>
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<tr>
<td>Gold</td>
<td>$600</td>
<td>$1200</td>
</tr>
<tr>
<td>Silver</td>
<td>$2000</td>
<td>$4000</td>
</tr>
<tr>
<td>Bronze</td>
<td>$3000</td>
<td>$6000</td>
</tr>
</tbody>
</table>

- 64% of insured polices carry a meaningful deductible

The average deductible consumers pay in America increased by 154% in the year 2013
For Health Exchange Products Providers will have to be collectors of significant patient financial responsibilities

<table>
<thead>
<tr>
<th></th>
<th>Bronze</th>
<th>Silver</th>
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<tr>
<td><strong>Deductibles</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Individual</td>
<td>$3000</td>
<td>$2000</td>
<td>$600</td>
<td>-0-</td>
</tr>
<tr>
<td>Family</td>
<td>$6000</td>
<td>$4000</td>
<td>$1200</td>
<td>-0-</td>
</tr>
<tr>
<td><strong>Out-of-pocket cap</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$6350</td>
<td>$5500</td>
<td>$4000</td>
<td>$2000</td>
</tr>
<tr>
<td>Family</td>
<td>$12700</td>
<td>$11000</td>
<td>$8000</td>
<td>$4000</td>
</tr>
</tbody>
</table>
And the patient pays and pays....

INCREASING OUT-OF-POCKET – EVEN AFTER THE DEDUCTIBLE
The virtual end of OON coverage

Out-of-Network Charges: Providers Charging Exorbitant Prices for Services

Health plans create physician networks to ensure patients have access to a wide choice of high-quality providers. Over decades, patients have saved billions of dollars in premiums and out-of-pocket costs by using in-network providers who have agreed to lower rates for their services. When patients receive care out-of-network, such as during an emergency or when a physician refuses to join a network, there is no limit to what providers can charge for these services.

A new report found that some out-of-network providers are charging exorbitant prices for services. In some instances, these charges are nearly 100 times more than what Medicare pays for the same service in the same area. When out-of-network providers are given a “blank check” to charge whatever they want, it drives up the cost of coverage and leaves patients with extremely high medical bills.

Highest Reported Out-of-Network Provider Charges Compared to Medicare Payments for 10 Common Medical Procedures

33 times
33 times
41 times
47 times
64 times
73 times
92 times
93 times
93 times
95 times

Out-of-Network Charges
Medicare Payments
Gallbladder removal surgery
$19,000
$5,071
Colonoscopy and biopsy
$26,000
$7,200
Cataract surgery with Intraocular lens
$9,266
$1,953
Office visits, Established Patient
$5,520
$1,181
With an E code (physician fees)
$12,000
$1,877
Emergency Department Visit
$25,958
$4,699
Upper GI Endoscopy Biopsy
$9,600
$1,609
Surgical Removal of Gastrointestinal Tissue
$27,310
$4,044
Critical Care, Prolonged Intensive Care Unit
$12,000
$1,901
Tissue Exam Pathologist
$2,471
Subtotal: Hospital Care

Nationally, approximately 88% of all claims were paid on an in-network basis in 2013.

88% In-Network
12% Out-of-Network

Some out-of-network providers are charging significantly higher prices than what Medicare pays for the same service in the same area.
Health Delivery Reform

ACO
Accountable Care Organizations

- Medicare Contract
- Providers contract to accept quality and efficiency risk for care provided to Medicare beneficiaries

Clinically Integrated Networks

- Commercial Contracts
- Providers contract with commercial plans on a variety of shared savings, incentive, capitation, and risk models to accept responsibility for care provided to commercial patients
ACO/CIN

**Triple Aim**
- Lower costs
- Increase quality
- Increase patient Satisfaction

**Tools**
- Cost
  - Population Health
- Quality/Cost /Satisfaction
  - Patient Centered medical Homes
  - Patient engagement
  - Transparency
- Bundled Payments
- Control
  - Narrow network – in ACO/CIN referrals
To Be In – Or Not To Be In

- Organizations are forming to do ACO and CIN
- Physician Driven
- Hospital Driven
- PHO Driven
- Who will make it and who will fail?
- Risk of being left out?
- Cost/risk of being included?
What the future holds

Mass Confusion,
Mass Destruction
And/or
Mass Disruption?
Security
- Hacking is free

Religion
- Expanding Impact

Business
- New competitors
- Coopition everywhere
- Peak everything

Health
- Longer life*
- Healthier life*
- Chronic is normal

Work
- Automation of “normal”
- Skills gap and need for reskilling
- Technology-enhanced employees

Law
- Relative stability

Government & Society
- Flattening world
- Pockets of instability

Demographics
- Older consumer
- Context is king

Science & Technology
- Bandwidth is distance

Energy
- Oil important, not king

Economy
- Water as currency

Transportation
- Security challenged
- Infrastructure impacted
- Tight economics

Environment
- Business measure
- Need to Know

Education
- Better educated*
- Distance learning

Food & Agriculture
- Stable currently but linked to environment

* Not all the * may participate
Trend: The demand for physician services is changing

**Transactional Patient**
- Seeking care
  - Fast
  - Cheap
  - Adequate Quality

**Patient-Patient**
- Seeking care from a physician and the “traditional patient-physician relationship”

**New providers/ Competition**
- Urgent Care
- Rx Clinics
- Telemedicine
Trend: Patient as consumer

<table>
<thead>
<tr>
<th>The Difference Between Patients and Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Patients</strong></td>
</tr>
<tr>
<td>Low: depend on physicians to make decisions on their behalf</td>
</tr>
<tr>
<td>Low: depend on physician opinion</td>
</tr>
<tr>
<td>High: based on personal experiences and word-of-mouth</td>
</tr>
<tr>
<td>Access within a reasonable timeframe + personal attention</td>
</tr>
<tr>
<td>Large networks of providers to enhance access and convenience + manageable out-of-pocket costs</td>
</tr>
</tbody>
</table>

| **Consumers**                                |
| High: depend on physician recommendation and personal verification |
| High: depend on online tools and social media |
| High: based on personal experiences and comparison shopping |
| Value: access + service delivery + outcomes + cost |
| Narrow networks of high-performing (high-value) providers + predictable costs |
Trend: There is no future in bricks and mortar

One-third of hospitals will close by 2020

Chart 3.4: Inpatient Days per 1,000 Persons, 1992 – 2012


Chart 3.11: Percentage Share of Inpatient vs. Outpatient Surgeries, 1992 – 2012
Trend: The composition of the medical workforce will change

Open question – to what extent will non-physician providers fill the shortage?
All trends will be driven by money

<table>
<thead>
<tr>
<th>Reforms</th>
<th>Estimated 10-Year Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-acute care payments based on beneficiary needs not setting</td>
<td>$45 billion</td>
</tr>
<tr>
<td>Stronger hospital incentives for coordinated post-hospital care</td>
<td>$10-15 billion</td>
</tr>
<tr>
<td>Equalize payments for certain outpatient and ambulatory services</td>
<td>$10-15 billion</td>
</tr>
<tr>
<td>Use competitive bidding for clinical laboratory payments</td>
<td>$8 billion</td>
</tr>
<tr>
<td>Phase in reforms in Medigap and Medicare benefit design</td>
<td>$20-40 billion</td>
</tr>
<tr>
<td>Encourage efficient prescription drug use by low-income beneficiaries</td>
<td>$30 billion</td>
</tr>
<tr>
<td>Increase income-related Medicare premiums</td>
<td>$60 billion</td>
</tr>
</tbody>
</table>

Devastating to hospitals
Does a job on hospitals and Labs
Any benefit reductions reduces income to providers
Trends will put increasing pressure on physician practice income

- The status quo is unsustainable

- Do nothing and participate in the decline of your practice

**Increasing Pressures on Physician Practice Income**

- Inadequate reimbursement
- Higher malpractice premiums
- Increasing administrative/overhead
- Longer receivable cycles
- Displacement of income-generating procedures through new technologies
  - Imaging advances have replaced need for some higher-reimbursed procedures and surgeries
- Competition from retail clinics and “lifestyle enhancement” alternatives
  - Health clinics and quick care centers (e.g., Walgreens’ Take Care™, Minute Clinics)
  - Patients are becoming more involved with programs that eliminate or reduce pain (pain centers, chiropractors), improve well-being/quality of life (fitness centers, massage centers), and improve their appearance (vein centers, cosmetic surgery, weight management programs)
- **Employers are becoming more active in health promotion**
- **Move toward new health management models (medical home, integrative medicine)**
- **Consumers are engaging more pro-actively in their health care diagnosis, treatment, and health maintenance**
Pragmatic responses

- Look internal to improve your income
  - Understand deductibles and the implications for your practice
  - Maximize all legitimate income opportunities
  - Watch your revenue cycle – bill, re-submit, and appeal
  - Understand the plans you par and are non-par – verify participation and individual eligibility

- Look internal to improve your patient base
  - Promote – market
  - Improve access to – YOU
    - Make room to say yes to capture patients same day
    - Add telemedicine?
  - Improve satisfaction w/YOU
    - Survey, listen, respond
  - Firm up your referral sources and make new ones
Pragmatic response

Look internal to understand your own performance
- Internal - your IT system
- External – payer data
- Use data to understand
  - Quality measures
    - HEDIS scoring
  - Cost measures
  - Payer performance programs
    - United premium Designation
    - CignaCare
    - Aetna Axcel

Look external at what is going on
- Don’t sit on the sidelines
  - Consider joining in various developing ACO/CINs
  - Evaluate and challenge them on their potential to be successful
- Re-asses you health plan participation
  - add or delete payers as appropriate
You can thrive in the evolving chaos

- Demand for private practice physician services has changed – not diminished
- The cost of pushing out the private practioner is becoming recognized
The difference between business and healthcare

In the business world
its dog eat dog
The difference between business and healthcare

In the business world
its dog eat dog

In health care
its completely reversed
Control your own destiny or someone else will.

- Jack Welch
Thank You