TRANSFORMING A HIGHLY DYSFUNCTIONAL HEALTHCARE SYSTEM

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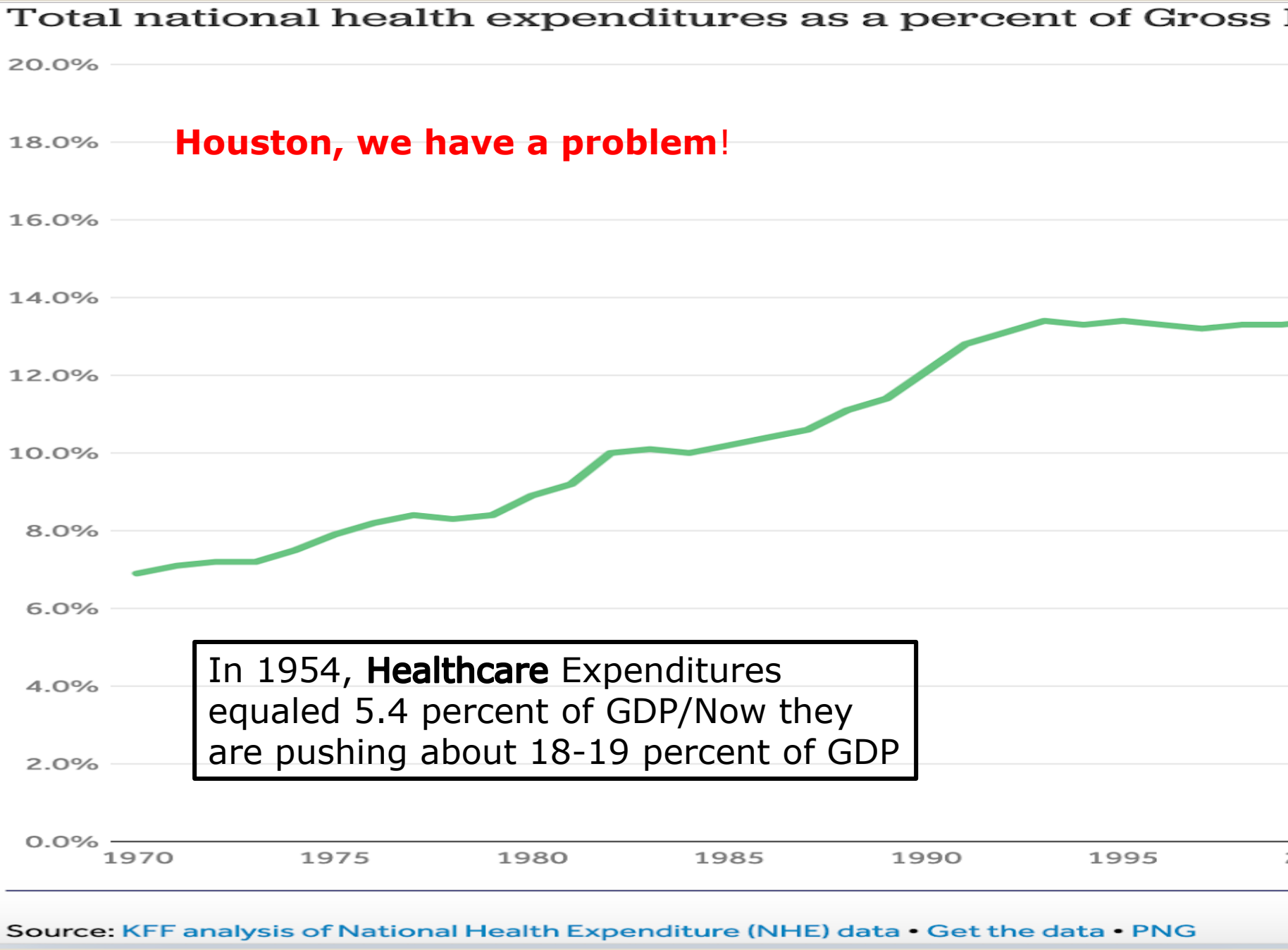
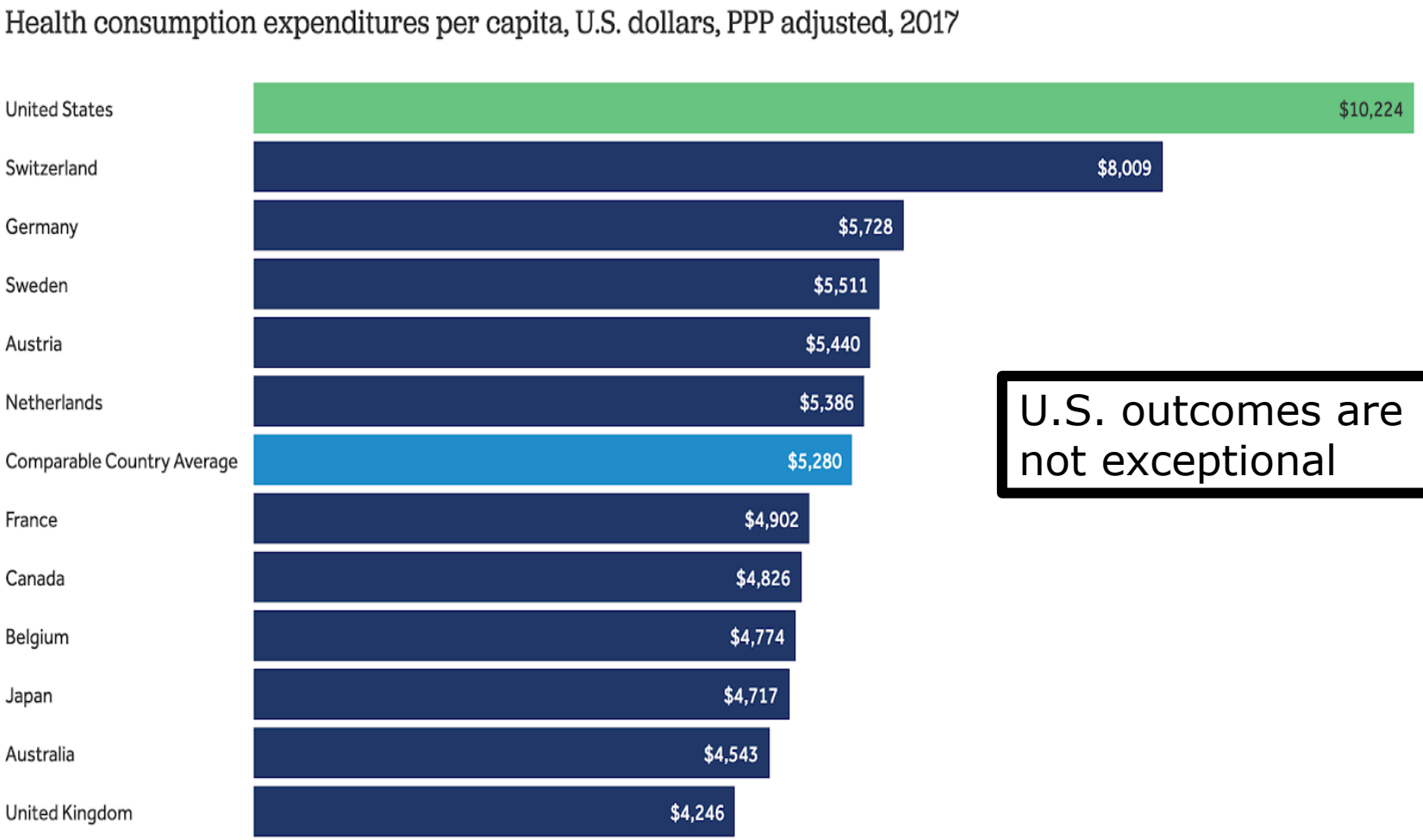

Total national health expenditures as a percent of Gross
20.0%
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
1970
1975
1980
1985
1990
1995
Houston, we have a problem!
In 1954, Healthcare Expenditures equaled 5.4 percent of GDP/Now they are pushing about 18-19 percent of GDP
Source: KFF analysis of National Health Expenditure (NHE) data • Get the data • PNG

The 1980s brought Managed Care; this did Not make a difference in containing costs

Healthcare as a % of GDP over the decades		
Year	% of GDP	% growth over previous decade
1960	5.0%	
1970	6.9%	38%
1980	8.9%	29%
1990	12.1%	36%
2000	13.3%	10%
2010	17.4%	31%
2017	17.9%	3%

On average, other wealthy countries spend about half as much per person on health than the U.S. spends



U.S. outcomes are not exceptional

Notes: U.S. value obtained from National Health Expenditure data. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of OECD and National Health Expenditure (NHE) data • Get the data • PNG

Peterson-Kaiser

THE PRESSING QUESTION: ARE WE GETTING OUR MONEY'S WORTH?

- Life expectancy 79.1 years in 2020 or 46th among industrialized countries
- Infant mortality rate 5.44 per 1000 live births (50 th among 195 countries reporting)
- In 2020, some 32.6 million Americans were uninsured.

Broad statistical databases support the fact that overall America ranks about 39th in healthcare quality and outcomes across the globe.

American Cultural and Infrastructural Realities that impede cost containment and value controls in our healthcare system

- ***Price inelasticity***
- ***Misplaced pay incentives***
- ***Deep pocketed vested interests***
- ***Changing Times: bigger is better?***

Price Inelasticity (an imperfect competitive/capitalistic market)

- "Doc what is it going to cost"? Asymmetry of medical information between patient & doctor.
- No price competition in healthcare services with fixed fees and reimbursements based on DRG (disease) and CPT (procedural) codes
- What is a quality-adjusted life-year of good health worth anyway? (QALY) No easy answer.
- In seminars, conferences and everyday interactions, providers and suppliers rarely mention cost.

Flawed Incentives; the Productivity/Assembly Line Model in Healthcare

- Our current system is a production model across all providers where compensation rests upon doing 'more rather than less'. You are paid by the **numbers** of patients seen and procedures/tests performed and not outcomes (pay for performance).
- The provider is also incentivized to play the 'up-coding' game to maximize reimbursements.
- Commerce in Healthcare overvalues specialty/interventional care and undervalues the more compassionate services of the primary care physicians.
- The 15 minute encounter time frame that hospitals and private equity impose on PCP causes them to burn out in high numbers, short change the patient and retire early.

Special Interests and Intermediaries with Deep Pockets and Requirements

- Hospitals, drug companies & PBMs, managed care organizations, manufactures of DME, employers, unions, medical schools, disease nonprofits and research facilities are big players with deep pockets and well-scripted strategies to maintain or increase their piece of the healthcare dollar. These huge enterprises have many lobbyists that seek to mold public policy.
- Within this scenario, the physician, Organized Medicine and the patient have lost the medical franchise and are out of the loop in crafting public policy especially in the current polarized political environment.
- As just one example, to get passage of the ACA, Obama and the Congress had to exclude the Public Option (Medicare) for the State Exchanges and proscribe Medicare's license to directly negotiate price with the drug companies. (two important steps in price containment)

Signs of the Times (Today Bigger, Better, and More Expensive)

- The U.C. Medical School in **1961** was a small building on Eden Ave with a mostly volunteer faculty
- Limited Student debt (tuition less than $2000 per year in 1958)
- Hospitals (small with few private rooms and nurses could care for 10-20 patients and just a handful of administrators)

Today:

- Huge physical plants; **gobs** of administrators
- High priced specialists with well over 125 specialties
- Expensive sophisticated equipment, precision medicine
- Boutique or subscription Medicine

Reiterating the Structural Problems

- *Price inelasticity*
- *Misplaced incentives*
- *Deep pocketed vested interests*
- *Changing Times: bigger is better*

MORE SPECIFIC DRIVERS OF HIGH MEDICAL COSTS AND STEPS THAT CAN BE TAKEN TO CONTAIN COSTS

Controlling Drug Prices

Solving the Transactional Maze in Healthcare

Decreasing transactional Health Insurance Costs

Reasons for Encouraging a Healthy Life style

Providing Universal Access to Appropriate Healthcare

Reducing Medical Mistakes

Maintaining and Improving the Standards of Care

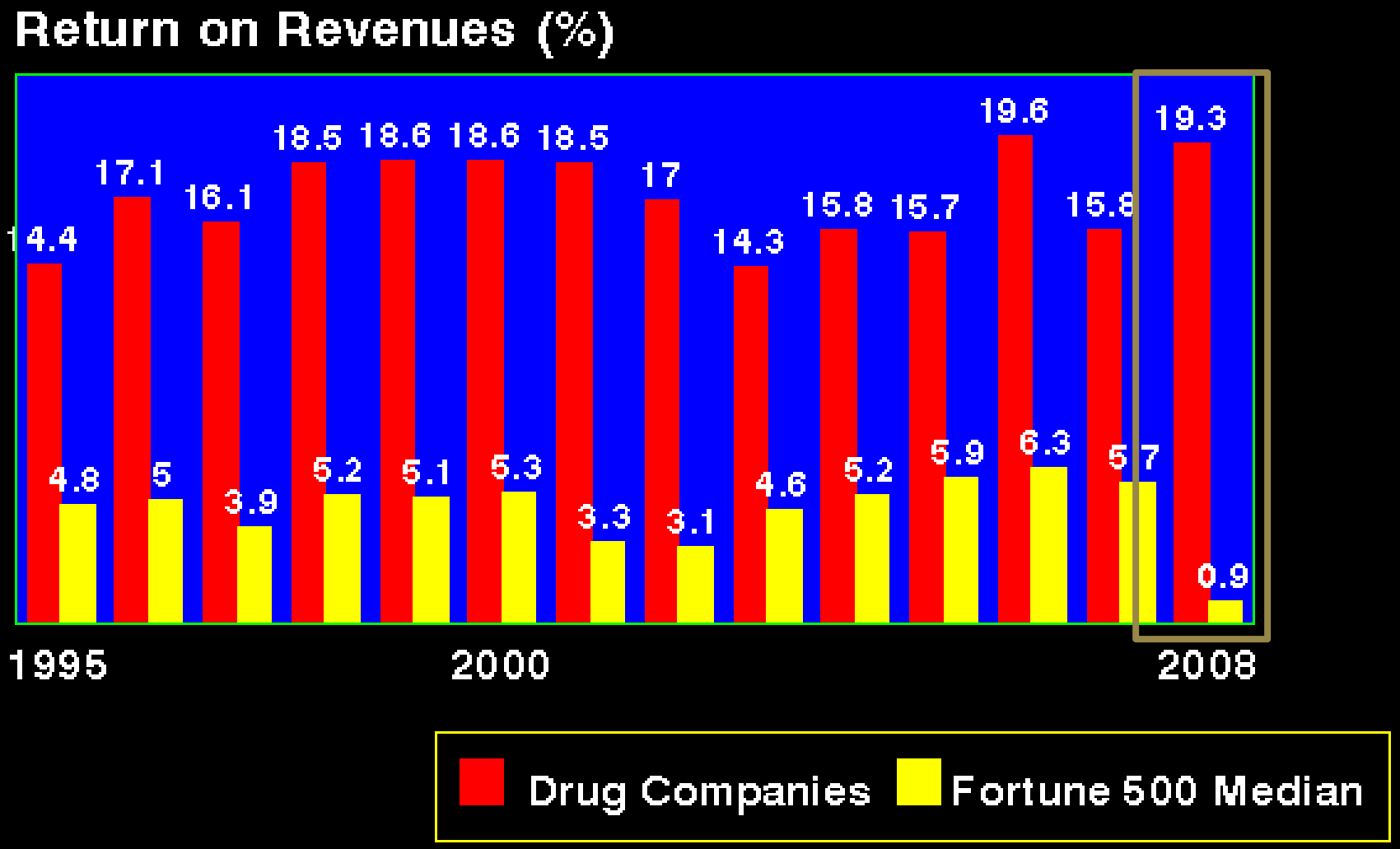
Integrating New Technology and Treatments

Reducing Duplication in the Healthcare system

Managing Drug Costs

- In past 20 years in 'inflation adjusted' dollars, drug expense per person has doubled and prescription drugs now consume 10-11 percent of healthcare costs. With the **biologics** rising 15% per year.
- Drug Companies have high profit margins and more revenue is spent on direct to the consumer advertising than R&D.
- PBM are huge intermediaries that end up being in bed with the insurance and drug companies rather than lowering costs for the consumer.
- Reasons foreigners pay 30-50 percent less for their drugs.

Drug Company Profits, 1995-2008



Source: Fortune 500 rankings for 1995-2008

Total drug company profits, 2008 = $51.6 billion

Solving the Transactional Maze in Healthcare

- EMRs, documentation and coding (139,000 ICD-10 codes) requirements that take up about **40% of a physician's** time plus staff time. ("if it was not documented it was not done!")
- Complex billing systems, accounts receivables and accounting issues to satisfy hundreds of insurance entities (including Medicare and Medicaid) that offer a plethora of different plans. **Who among you can understand hospital charges**? NO ABC costing!

More onTransaction Expense

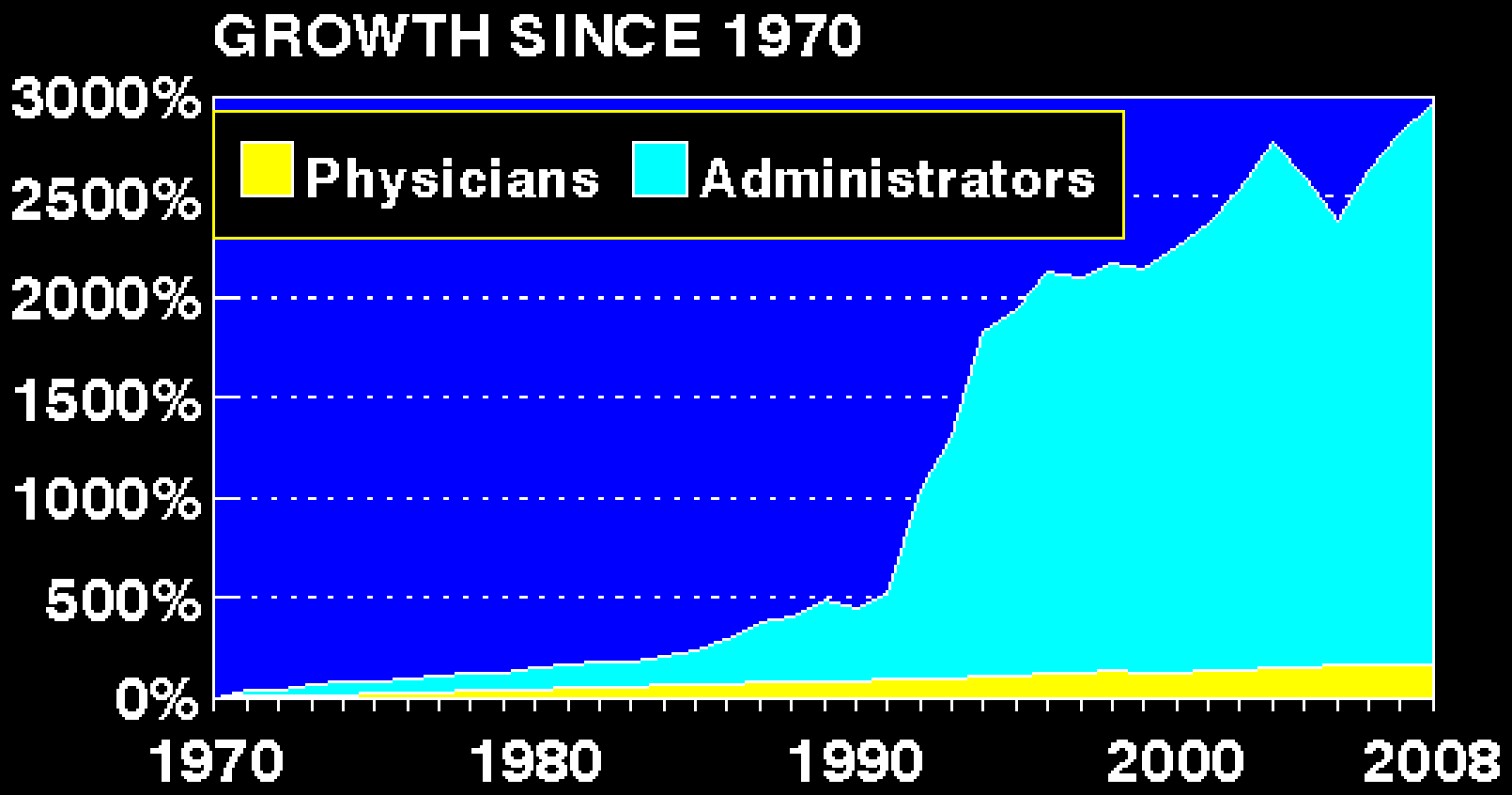
- Employer based insurance coverage with contracts(another layer and COBRA as well)
- CLIA and OSHA and HIPPA compliance

To satisfy these transactional issues you need higher paid specialized office and hospital personnel

By the way,

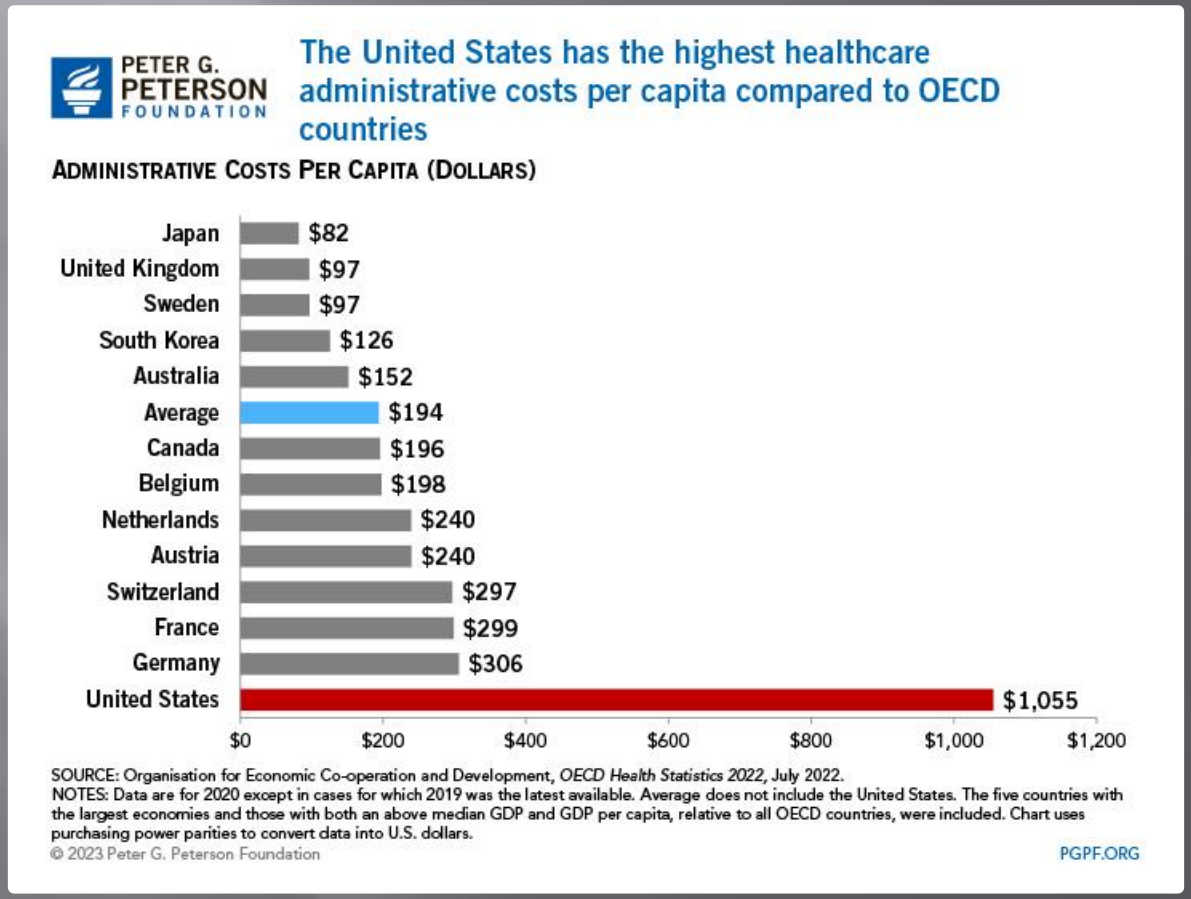
what ever happened to the promise of a paperless office through the rise of sophistocated Information Technology systems?

Growth of Physicians and Administrators 1970-2008



Source: Bureau of Labor Statistics; NCHS; and analysis of CPS

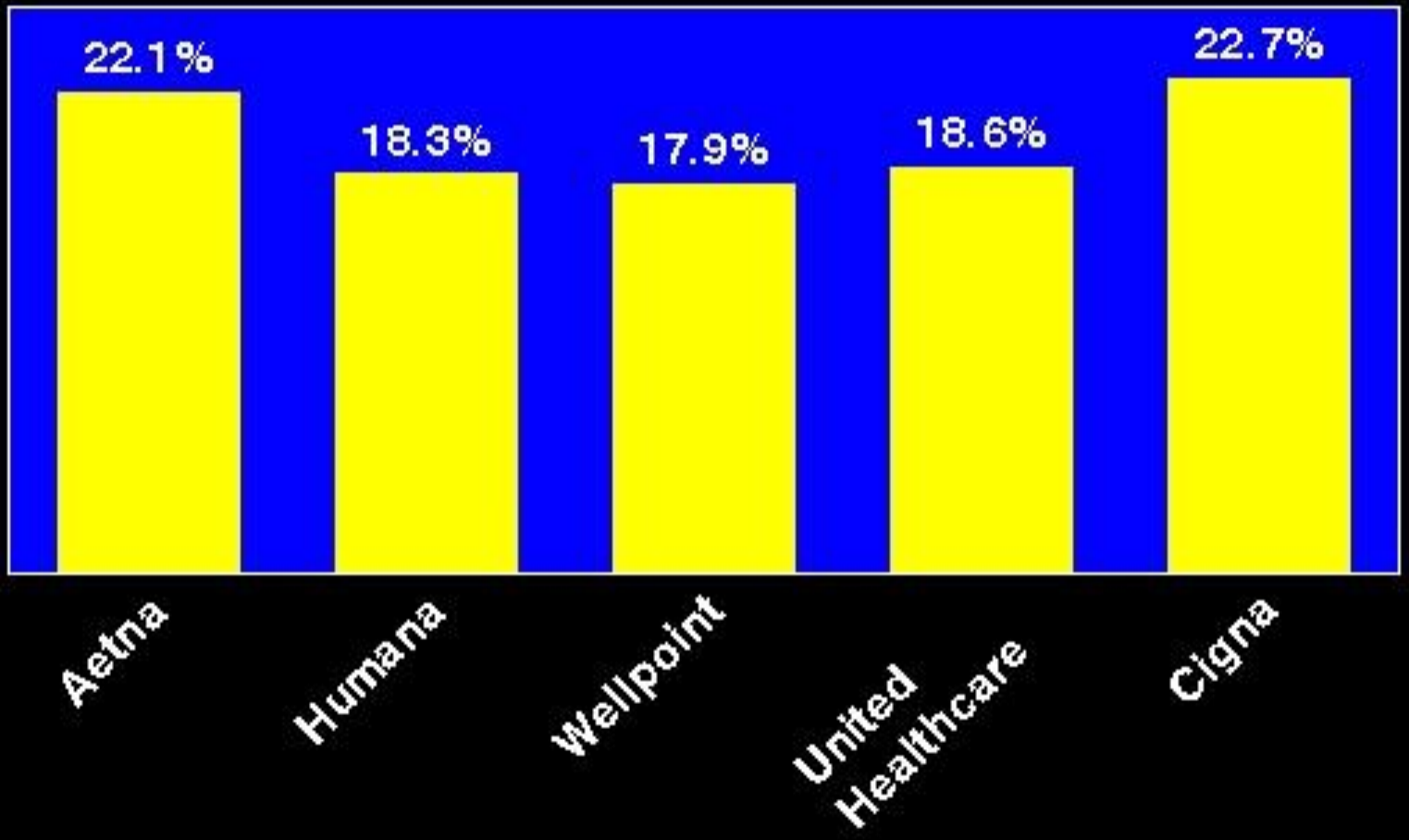
Gross administrative costs.



Intermediation: Health Insurance and Managed Care Organizations

- Health Insurance is a non-value added component of healthcare with high administrative expense and five percent profit. Under the ACA 85% must go toward patient care. (creative bookkeeping)
- Vast number of large competing companies with a myriad of plans that vary between individual employers and individuals with each plan having its own set of rules, coverages, carve outs, copays, panels of providers, specialized application forms, pre-authorizations, appeal processes, contact information and drug formularies.
- Objectively, these intermediaries do nothing but add many layers of transactional expense and pay the bills much like MasterCard or Visa.
- Medicare administrative expense is only 3 percent

HMO Overhead, 2011



Source: SEC Filings/Reports to shareholders - Figures are for Q1 or Q2
Calculated as 100-Medical Loss Ratio
Note: Figures for Wellpoint and UnitedHealthcare include non-commercial enrollees

Reasons for Encouraging a Healthy Life Style

- Greater number of chronic conditions; especially related to the metabolic syndrome (people in large bodies, HPT, hypercholesterolemia, adult onset of diabetes) that increase healthcare costs.
- High cost of dying in our society; encourage the new specialty of palliative care and death with dignity.

Providing Access to Appropriate Health Care for Everyone (a cost savings strategy)

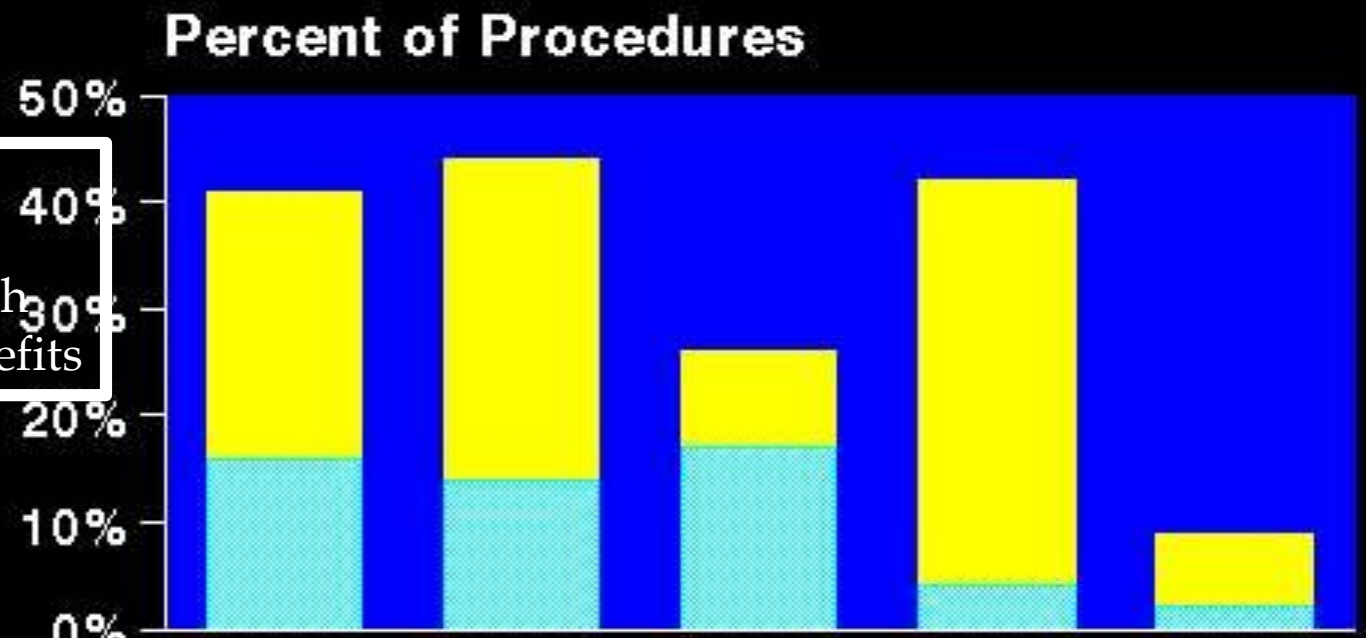
- Before the ACA, about 44 million Americans had no health insurance and this generally young and healthy population often use the 'high cost' Emergency Departments as their primary care physicians and seek help at a later stage of disease progression and neglect preventive care (medical bill account for the majority of bankruptcies).
- Lack of access to care is reflected in our nation's actuarial survival statistics.
- **Medicine today must be considered a right rather than a privilege**
- A single payer system is a socialized insurance system and not socialized medicine.

Maintaining and Improving Standards of Care

- Patterns of practice used to vary greatly between providers. Some estimate that as much as 30% of care is unnecessary. (an incentive problem?)
- Uniformity and Quality are improving with greater oversite, big data and AI (Artificial Intelligence) that is and will define standardized algorithms of care. (may come a day when there is a surplus of Physicians)

Unnecessary Procedures

I would call
It marginal
Therapies with
Marginal benefits



	Hysterectomy	Bypass Surgery	Angio-graphy	Angioplasty	Cataract Surgery
Questionable	25%	30%	9%	38%	7%
Inappropriate	16%	14%	17%	4%	2%

Source: Commonwealth Fund - Quality of Health Care in the U.S. Chartbook, 2002

Integrating New Technologies and Treatments

- Flood of new innovations especially biologic pharmaceuticals: 575 approved by FDA and all come with a high price tag.
- **Most are not curative and most require long-term treatment for chronic ailments**

Long term solution?

- IT that can crunch 'big data' that is shared across the provider spectrum to create algorithms of standards of care (precision medicine) and robotics to be front line workers managing triage and office processes.
- Artificial Intelligence.
- Will the MD degree in the future still guarantee life long employment?

Redundancy in the Hospital Systems

- The hospitals are a big part of the problem as they compete furiously for market share to become monopolies/oligopolies and charge what the traffic will allow. (Price fixing?)
- Expansion and duplication of bricks and mortar facilities,, multispecialty groups, surgery centers, testing facilities and intrusion of private capital.
- No CONs and regional or national planning
- Huge endowments as not-for-profit entities.

It is rumored through marketing that there are five hospital systems in Cincinnati area that have the best orthopedic and cardiac units in the nation and each boasts of having the 'best group of employed physicians.'

How do other countries deal with healthcare?

Across the Westernized world **universal** health care is almost universal with **thirty-two of the thirty-three developed nations** providing it; the sole exception being the United States. In recent decades, public opinion has evolved to where the majority of U.S. citizens now consider access to quality healthcare to be a right reflecting social justice and morality rather than a privilege.

My Opinion about the immediate, but temporary, Steps to Partially Solve the crisis in Healthcare

***The First Steps*:**

Reinstate the ACA or Obamacare in its original form to include:

- 1. The Federal Mandate (universal coverage or pay a fine or penalty)
- 2. Coverage for all preexisting conditions (no cherry picking!)
- 3. Reconfirm a standardized package of healthcare benefits

Additional Initial Steps that would need Congressional Approval

1. Permit Medicare to negotiate drug prices directly with the pharmaceutical companies, create formularies and limit the intermediary role of PBMs.
2. Strengthen the State Health Insurance Exchanges and offer the Public Option on the Exchanges (Standard Medicare with Advantage and Supplemental plans) as a competitive offering
3. Mandate Standardized Federally subsidized State Medicaid programs

Salient Questions to Address

- How do you transition to a single payer universal system with the least amount of disruption to the economy and jobs market?
- How do you make rational cost projections for the implementation of a new system and how do you pay for it? (does this eliminate employer based healthcare?)
- How do you integrate or assimilate 'big' data and population based/capitation models into the healthcare system?

More Salient Questions to Address

- What healthcare system has worked best in other countries; lessons learned?
- How do you address the ethical issues of rationing of medical care, cost/benefit ratios, and end of life futile care?
- Do you have a 'one size fits all' system or a two or three tiered system of healthcare?

One More question; What if you have a single payor system or 1200 pound gorilla?

- How would it replace the current 'production" incentive system that links compensation with 'doing more' and substitutes pay for outcomes and performance?
- How do you define representative 'populations' across all age groups and regions to enable a 'capitated' or population based' system to function based on valid data that is risk adjusted, factors in academic medicine, pay for performance and quality of care?.

Some Personal Ideas?

- Phase in Medicare by lowering age of enrollment by three years per year over 15 years. Enroll all children in the new program.
- Encourage health insurance companies to take over some of the back office functions in the large healthcare providers and help with the formation of a two tiered or three tiered system.
- Offer Medicare as an option in the exchanges and take steps to merge Medicare and Medicaid.

More Issues

- A capitation or population based model that shares risk with large institutions might limit patient choice; is this an issue?
- A two tiered fee based system for emergency care, overseas care, outside providers and facilities such as the Cleveland Clinic or Mayo Clinic administered by Insurance Companies as standalone products. Fuse and standardize existing Advantage and Supplemental plans for this product and rural areas that have no healthcare provider.

At the End of the Day

- Probably, the healthcare system will continue to receive many band aids for politically popular issues in the years to come. At some point, maybe 5 years, or 10 years or 20 years we will have a single payer system or a socialized healthcare insurance system. In my opinion, the current private healthcare sector is so dysfunctional that I see no other solution; especially with a congress that suffers from chronic gridlock and a populace that is so divided on healthcare issues and the other entitlement programs.