MANAGED CARE :

THEN, NOW AND TOMORROW

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OUTLINE

- **Current Situation**
  - Criticisms
  - Perspectives
- **Managed Care**
- **Affordable Care Act (ACA)**
  - Highlights
  - Reforms
  - Challenges
  - Implications for Stakeholders
- **Stakeholder Perspectives**
- **Unknowns?**
- **Opportunity!**

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OUR WORLD

- **People**
  - Babies: infections
  - 20-40 y/o: child birth
  - Elderly: co-morbid
  - Adverse Selection
- **Habits & Wants**
  - Infinite demand for QOL
  - Enjoyment over benefit
  - Limited resources
- **Medicine**
  - High touch
  - Low productivity
  - Treatment over prevention
- **Insurance**
  - None → self-treatment
  - Business provided
  - Medicaid / Medicare
  - Re-insurance
  - Social Security around the world
- **Unfulfilled Promises**
  - Information over knowledge
  - Cost over affordability
  - Unfettered life over risk management

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CRITICISMS OF CURRENT HEALTH CARE SYSTEM

- For Profit vs. Not for Profit
- Health Care Services
  - Overuse
  - Fragmentation
  - Overemphasis on Technology
  - Cream-Skimming
- Leading to High Cost, High Trend, High Utilization BUT Low Value

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BROKEN HEALTH SYSTEM

- Rising Health Insurance Premiums
- Loss in Employer Coverage
- Drain on the Economy
- Low Scores on Key Health Indicators
- Growing Number of Uninsured
- Concentrated Health Markets

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THE SITUATION

- US Health Care Spending
  - $2.6T / year
  - 18% of GDP
  - $8,402 / person
- Related to deficit, unemployment, wages
- 60% of bankruptcies attributed to medical bills (2009)
- 75% of health care is for people w/co-morbidities
- Aging baby boomers → higher utilization
- High % of people undiagnosed (e.g., 50% of people with Hep C)
- Medications managed under different benefits (e.g., medical vs. pharmacy)
- Quality/Value are patient-centered but under-utilized

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PRINCIPLES OF MANAGED CARE: HISTORICAL

- Rate setting for specific health care services
- Fees set according to a sliding scale ability to pay
- Owners pay for health care for slaves
- Objective outcome measurement standards to assure quality of care
- Outcomes information management to include data collection and evaluation
- Consumer and patient's rights publicized, explained and made known

Codex Hammurabi, 1700 BC

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CARE TO MANAGED CARE: TODAY

- **GOALS**
  - Optimal Therapeutic Benefit
  - Minimal Acceptable Risk
  - Affordable Cost
- **Conceptual / Operational Changes**
  - Silos to Interconnectivity
  - Solo Practice to Groups
  - Profit/Individual to Profit/Group
  - Technology:
    - Early adopter low utilization and high cost
    - Mature market of managed utilization and lower cost

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HEALTH CARE REFORM (ACA)

- 3 Goals
  - Access: increase health care insurance coverage
  - Quality: improve care
  - Cost: reduce cost
- Individual Mandate = Access: most Americans required to have health care insurance by 2014 or pay a fine
- Insurance Reform = Underwriting to utilization management

AFFORDABLE CARE ACT (ACA): HIGHLIGHTS

- Coverage
- Focus on Transparency
- Insurance Market Reforms
- System Efficiencies
- Delivery System Reform
- Focus on Prevention and Wellness

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ACA HISTORICAL CONTEXT

	100 Years of Proposals	Activities
Early 1900s	Progressive platforms	National health insurance excluded from the final draft
1934-1939	New Deal	Social Security took precedence over health care benefits
1945-1950	Fair Deal	Labor split and AMA vigorously opposed
1960-1965	Great Society (Medicare & Medicaid)	AMA opposed creation of Medicare but lost the debate
1970-1974	Nixon vs. Kennedy	Competing plans split the cause
1992-1994	Clinton's attempt	Opposed by every major health care stakeholder group
2009-2010	Affordable Care Act	Legislation passed despite significant and continuing opposition

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ACA HEALTH INSURANCE REFORMS

- Guaranteed Issue
- Community Rating
- Essential Health Benefits (EHB)
- Limits on Policies that Impose Cost Sharing

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ACA DELIVERY SYSTEM REFORMS

- Accountable Care Organizations (ACOs)
- Value-Based Purchasing
- Readmissions
- Hospital-Acquired Conditions
- Bundled Payment Pilot
- Other Initiatives

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ACA IMPACT

MEDICAL

- Dependent coverage extended to age 26
- Increased coverage of preventative services
- High risk pools for people with pre-existing conditions
- Prohibition on rescinding coverage
- Elimination of lifetime limits on insurance coverage
- Health insurance tax credits for small business
- Review of “unreasonable” insurance rate hikes
- Impose rebates based on Medical Loss Ratios for Health Plans
- Funding for innovations to reduce costs

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ACA IMPACT -- PHARMACY

PHARMACY

- 2010: $250 rebates for seniors in donut hole
- 2011: 50% discount for seniors in donut hole
- Accountable Care Organizations:
  - Pharmacists in medical groups, businesses, Health Plans, PBMs, HR consulting, acute care, step-down care, long-term care, hospice, PhRMA, drug discovery and development
  - Pharmacists as providers
  - Pharmacists as care extenders
- Medical Homes:
  - Pharmacists as members of team

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HEALTH INSURANCE EXCHANGES

Every State must have an Exchange by 2014

- 24M expected to use Exchanges by 2019
- Low& moderate income can access coverage thru subsidies
- Small business with < 100 employees can buy coverage through Exchanges or provide vouchers for individuals to buy insurance

Currently

- 50M people in US are uninsured
- 2001-2009: Number of small companies offering insurance has ↓
- Health insurance premiums
  - 2001 = $5,269
  - 2011 = $10,944
- Worker Contributions
  - 2001 = $1,787
  - 2011 = $4,129

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ACA: THE FUTURE OF HEALTH INSURANCE EXCHANGES

- Employer sponsored insurance continues
  - Small business tax credits to fund coverage
  - Penalties and fees for employers that don't provide coverage
- Large companies can access Exchanges in 2017

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IMPLEMENTATION CHALLENGES

- Tight Implementation Timeframes
- Scarce Administrative Funds ($1B for ACA vs. $1.5B for MMA)
- Complicated Statute
- Reality of Pre-ACA Market
- No single person in charge of IT Build
- Well-Funded and Fervent Opposition
- Significant Public Confusion
- Reluctant Governors
- Late start on Enrollment

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PERSPECTIVE: MEDICAID & MEDICARE PART D

- When Medicaid was implemented in 1966:
  - Only 6 states signed up initially
  - 27 states quickly followed
  - 11 more states in 1967
  - 8 states in 1970
  - Last state to adopt Medicaid was Arizona in 1982
- Upon rollout in 2005, Medicare Part D:
  - 27% understood the law
  - Only 21% were in favor of the law
  - Computer glitches in moving “dual eligibles” from Medicaid to Medicare

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MEDICARE / MEDICAID CHANGES

- Currently -- 100M low income, disabled, elderly Americans
- Expectations –
  - Individual market will be covered by Medicaid
  - Medicare will ↑d/t aging population → 50% of health care spend

PAYER IMPLICATIONS

- Payers / Purchasers
  - Direct Care Delivery Services to Doctors
  - Participate in the 85% MLR
  - Creating Clinical Networks / Narrowing Networks
  - Buying Physicians / Groups

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EMPLOYER IMPLICATIONS

- Revenue / Fees / Taxes imposed on Insurers, PhRMA, and Device Makers will be passed on to consumers
- Reimbursement Rates to Hospitals/Providers likely to increase to compensate for Medicare cuts
- Provider Shortage
- Stop Loss Premiums Impact
- Health Improvement is Key
- Employees seeking information from Employers

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POPULATION HEALTH

VOLUME TO VALUE

- **Hospitals**
  - Employing Physicians
  - Risk contracts
  - ACO Experiments
  - Creation of new health plans
  - Vertical integration
  - Greater emphasis on ambulatory and post acute
- **Physicians**
  - Aggregating aggressively into IPA's, Medical Groups
  - More risk
  - Employed by plans and hospitals

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HEALTH PLANS: NOW & FUTURE

- Plans focused on small business market – shift from B2B to "B2Consumer"
  - Consumers expected to want **restricted networks, formularies and benefits** to lower premiums
  - Plans will need to understand how to **market to diversified consumer** segments and **demonstrate lower costs**
- Elimination of annual and lifetime $ limits on essential health benefits

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HEALTHCARE REFORM AND PHARMACY

- Medication Differentiation
  - Emphasis on quality and value
- Volume of Patients → digitized clinical pharmacy
- Monitoring by Tele-Pharmacy
- Cost Control
  - Brand to generic
  - Specialty to Biosimilars
  - Clinical outcomes vs. unnecessary costs

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TODAY TRANSFORMS TOMORROW

- Human genome sequencing rapidly and affordably
- Sensors to remotely track physiologic metrics (e.g., vital signs, glucose, IOP)
- Smartphone lab-on-a-chip to assay routine chemistry
- Digitize medications to ensure compliance
- Physical examination by Smartphone

IMMEDIATE TOMORROW IS ALREADY HERE!

- Digital infrastructure expansion
  - Increasing bandwidth
  - Pervasive connectivity
  - Cloud/super-computing
  - Social networks expand
  - Mobile device expansion
- Medical transformation
  - More precise
  - More individualized
  - More democratized

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TOMORROW

- All of this will change :
  - Diagnostics
  - Imaging
  - Medical devices
  - Operations, e.g., office visits, hospitals, medical informatics
  - Pharmacy
    - Dispensing to robotics
    - Screening Rx to digital, telemedicine
    - Monitoring individuals to populations, informatics

UNANSWERED QUESTIONS

- Will Exchange Enrollments hit targets? Newly or already Insured?
- Will Enrollees figure out how to pay their Premiums and Copays?
- Will we have enough PCPs?
- Will Hospitals see No Pay convert to Some Pay?
- Will Hospitals learn how to Take Risk?
- Will Private Exchanges change the face of Managed Care?
- How will we Pay for all this Change?

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OPPORTUNITY KNOCKS

- **Maximum Therapeutic Benefit**
  - Masters of Decision Analysis
  - Masters of Critical Appraisal
  - Information Sharing
- **Minimum Acceptable Risk**
  - Utilization Management
  - Collaboration with other Providers
  - Communication with Patients
- **Affordable Cost**
  - Comparative Cost Analyses
  - Cost-Effectiveness
  - Affordable Options

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WRAP UP

- **Volume to Value!**
- Maximal Benefit
  - What is quality? What is valuable?
- Monitoring and Valuing Risk
  - What is the value of personal responsibility?
- Cost vs. Value
  - How does medical technology transform?

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