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!**
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
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
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
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
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
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
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
# ACA HISTORICAL CONTEXT

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ACA HEALTH INSURANCE REFORMS

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

- Accountable Care Organizations (ACOs)
- Value-Based Purchasing
- Readmissions
- Hospital-Acquired Conditions
- Bundled Payment Pilot
- Other Initiatives
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
2010: $250 rebates for seniors in donut hole
2011: 50% discount for seniors in donut hole
Accountable Care Organizations:
  o Pharmacists in medical groups, businesses, Health Plans, PBM, HR consulting, acute care, step-down care, long-term care, hospice, PhRMA, drug discovery and development
  o Pharmacists as providers
  o Pharmacists as care extenders
Medical Homes:
  o Pharmacists as members of team
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
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
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
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
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
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
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
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
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
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
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?
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
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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