Implementing Health Reform Closer to Home

AAMC
Tomorrow's Doctors, Tomorrow's Cures

Learn
Serve
Lead

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(Please Note: This presentation does not represent an endorsement by the AAMC)

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American Medical Colleges

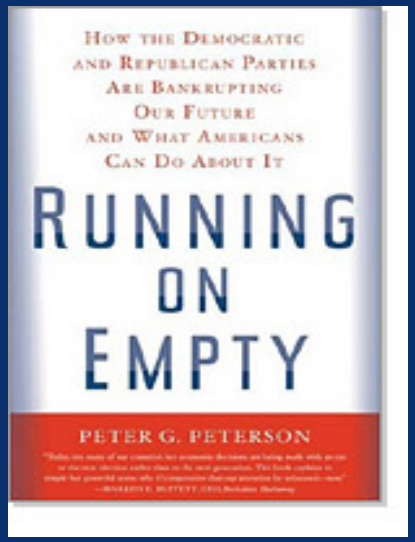
Is Healthcare the 'Greece' Tipping Point for the U.S.?

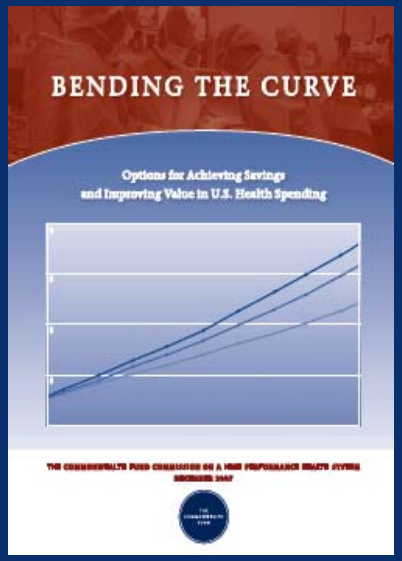
1. We have a wholly unsustainable "system"

2. Universal Coverage + Financing ≠ Reform

3. Pre-occupation with the Revenue Curve *(which we are incredibly parochial and protective of)*

4. Real reform lays under the Cost Curve by eliminating the waste, duplication, redundancies, inefficiencies, unnecessary variations *[redeploy $650B of $2T (or $1T of $3T)]*





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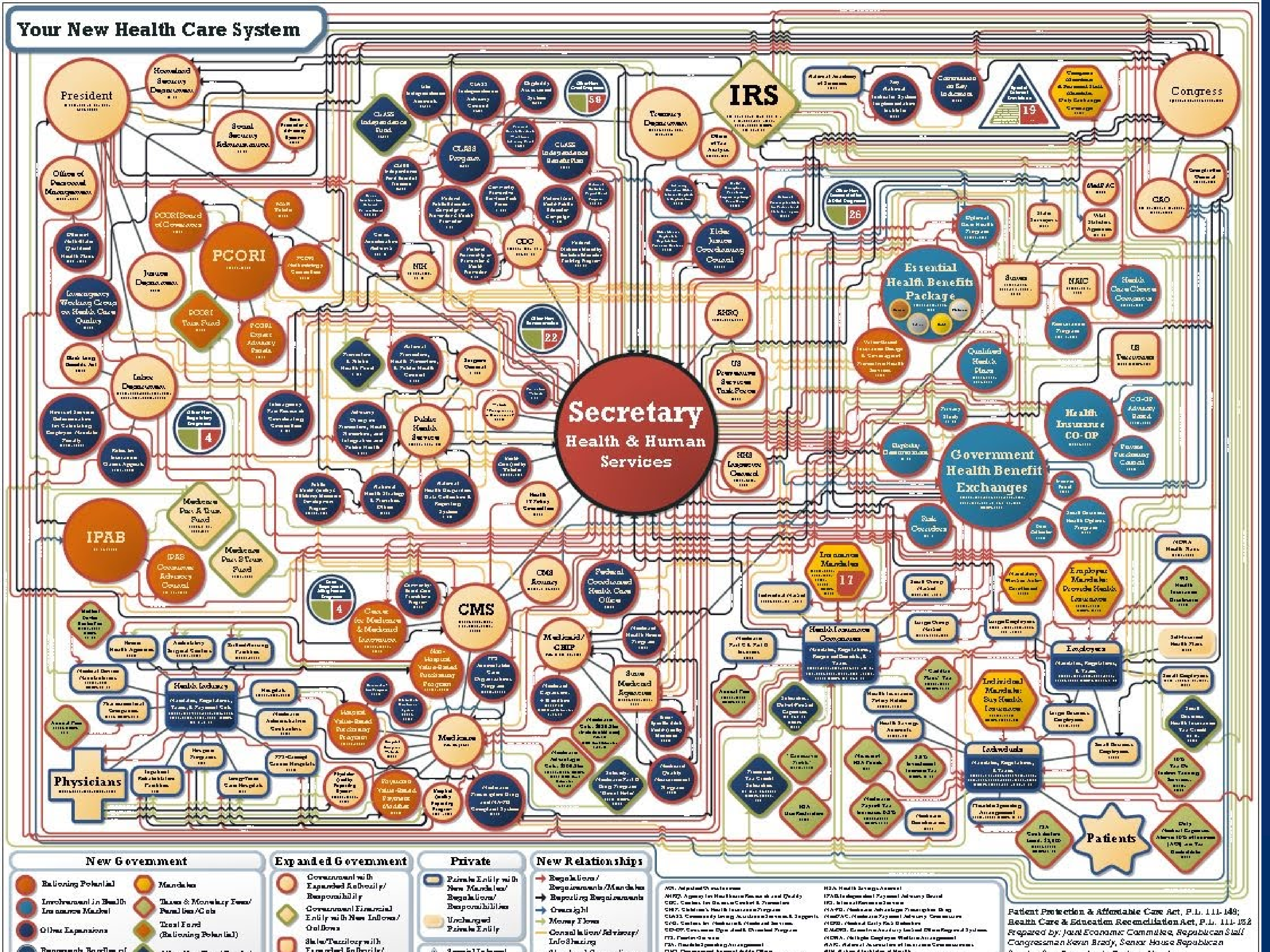

Your New Health Care System
President
Congress
IRS
Secretary
Health & Human Services
PCORI
IPAB
CMS
Physicians
Patients
Essential Health Benefits Package
Government Health Benefit Exchanges
Health Insurance CO-OP
CLASS Program
CDC
NIH
Medicare
Medicaid/ CHIP
Labor Department
Treasury Department
Insurance Mandates
Employer Mandate: Provide Health Insurance
Individual Mandate: Buy Health Insurance
Employers
Individuals
CBO
New Government
Rationing Potential
Mandates
Involvement in Health Insurance Market
Taxes & Monetary Fees/ Penalties/Cuts
Other Expansions
Trust Fund (Rationing Potential)
Expanded Government
Government with Expanded Authority/ Responsibility
Government Financial Entity with New Inflows/ Outflows
Private
Private Entity with New Mandates/ Regulations/ Responsibilities
Unchanged Private Entity
New Relationships
Regulations/ Requirements/Mandates
Reporting Requirements
Oversight
Money Flows
Consultation/ Advisory/ Info Sharing
Patient Protection & Affordable Care Act, P.L. 111-148;
Health Care & Education Reconciliation Act, P.L. 111-152
Prepared by: Joint Economic Committee, Republican Staff
Congressman Kevin Brady, Senior House Republican

Current Version of “Health Reform”

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Why This Time is Different…?

The NEW ENGLAND JOURNAL of MEDICINE

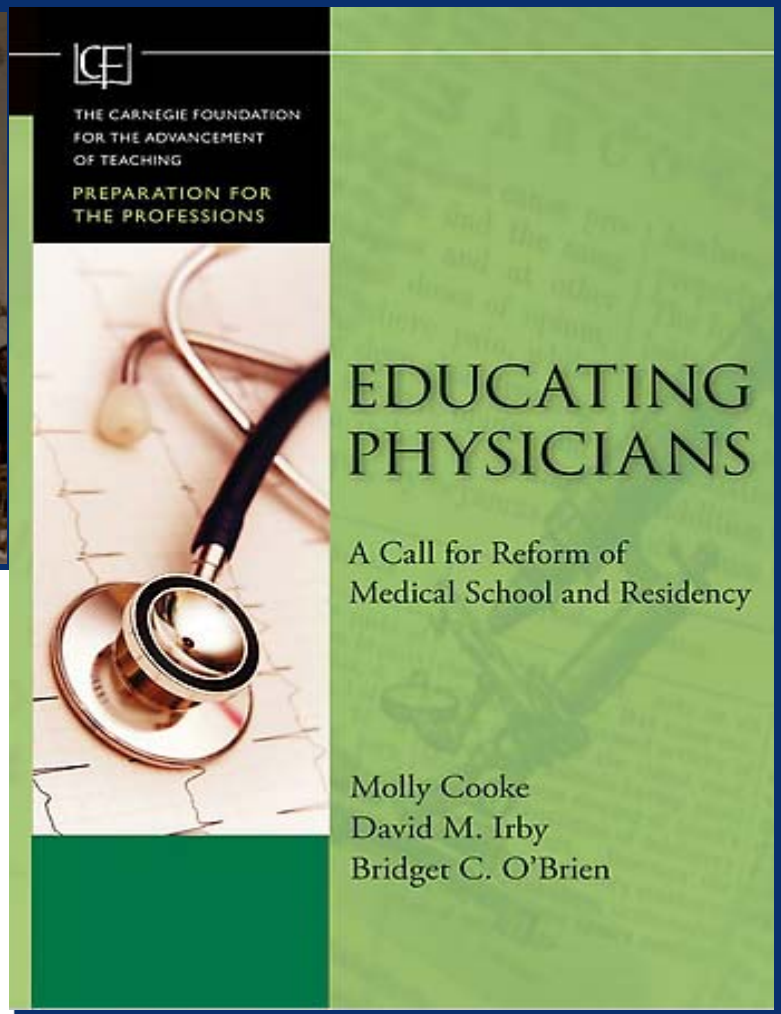
The Specter of Financial Armageddon — Health Care and Federal Debt in the United States

Michael E. Chernew, Ph.D., Katherine Baicker, Ph.D., and John Hsu, M.D., M.B.A., M.S.C.E.

The most important force shaping the U.S. health care system over the coming decades may well be the federal debt. The government now pays for approximately half of all health care costs in the United States, and projections of growing federal debt largely reflect anticipated increases in health care spending. Because federal debt and health care policy in the

clical and structural. Cyclical deficits rise or fall in the short term in response to economic conditions. In economic downturns, tax revenue falls and government spending on public programs such as unemployment insurance increases, leading to larger deficits and higher debt. These deficits are not necessarily a problem: they can boost economic activity and mitigate economic down-

This federal health care spending amounted to 5% of the gross domestic product (GDP) and 20% of federal outlays in 2009 and is forecast to reach 12% of the GDP by 2050.[1] Health care spending is thus a key driver of long-term debt. This does not mean that we cannot run a structural deficit, but deficits must be small enough that debt grows more slowly than the GDP.



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"Health Reform“ Impacts?

↑ Access = ↑ Demand + Continued Perverse Incentives = ↑ ↑ Costs
(which will burden margins & potentially stress the ability to cross-subsidize)

↑ Demand + ↑ ↑ Costs = ↓ Value = ↑ Upset

↑ consolidation of health plans, hospitals

↑ consolidation of physicians in larger medical groups and employed vehicles

SGR non-fix & CBO (re)calcs add another $400B to the $1T increased spend

NIH funding likely to be → (or possibly ↓)

GME funding likely to ↓ ($30B at-risk over 10 years through MedPac or IPAB)

Identifying Gaps vs. Filling Gaps

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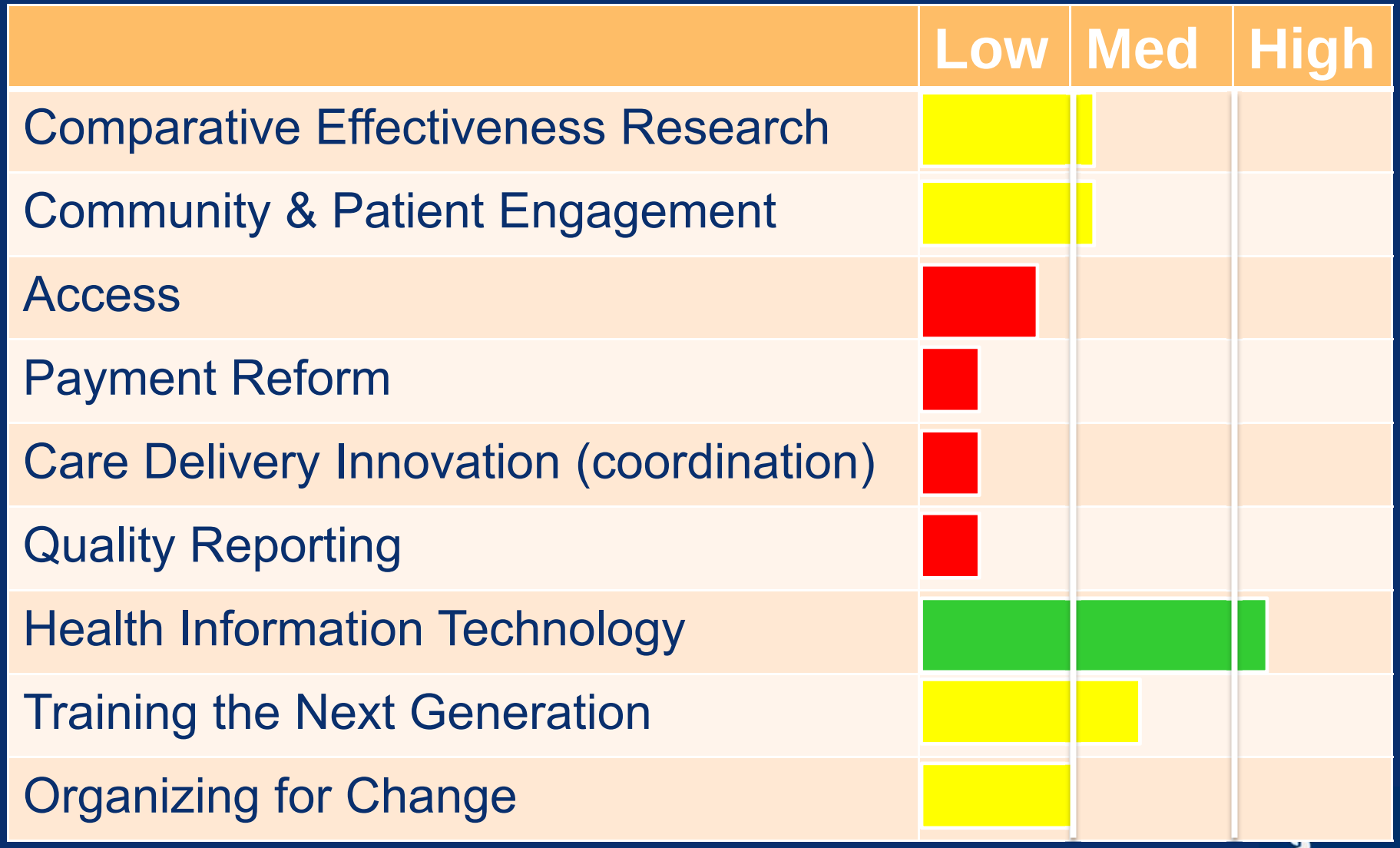
Respondents

Atlantic Health
BJC HealthCare
Boston Medical Center
Cedars-Sinai Medical Center
Children's Hospital
Children's Hospital Central California
Children's Hospital of Philadelphia
Christiana Care Health System
Cleveland Clinic Foundation
Dartmouth-Hitchcock Medical Center
Drexel University College of Medicine
Duke University Health System
Emory Healthcare
Fletcher Allen Health Care
Froedtert Hospital and Health System
George Washington University Hospital
Greenville Hospital System
Health Alliance of Greater Cincinnati
HealthPartners, Inc.
Henry Ford Hospital
Hospital of the University of Pennsylvania
Howard University Hospital
INOVA Fairfax Hospital
LeBonheur Children's Medical Center Medical Center
Lehigh Valley Hospital
Loma Linda University School of Medicine
Maimonides Medical Center
Massachusetts General Hospital
Medical College of Georgia Hospital and Clinics
Medical University of South Carolina Medical Center
Methodist Hospital
Montefiore Medical Center
NewYork-Presbyterian Hospital The University Hospital of Columbia and Cornell
Northwestern Memorial Hospital
NYU Hospitals Center
Oakwood Hospital and Medical Center
Oregon Health & Science University
OU Medical Center
Palmetto Health
Saint Francis Hospital and Medical Center
Saint Louis University Hospital
Saint Luke's Shawnee Mission Health System
Southern Illinois University School of Medicine
St. John's Mercy Medical Center
Stony Brook University Hospital
Strong Memorial Hospital
SUNY Downstate Medical Center/University Hospital of Brooklyn
The Milton S. Hershey Medical Center
Truman Medical Center Hospital Hill
U of L Health Care University Hospital
UCLA Medical Center
UCSF Medical Center
UMass Memorial Health Care
UNC Health Care System
University Health System
University Hospitals Case Medical Center
University Hospitals HeatlhSystem
University of Alabama School of Medicine
University of California, Davis, Health System
University of Chicago Division of the Biological Sciences The Pritzker School of Medicine
University of Colorado Hospital
University of Iowa Hospitals and Clinics
University of Kansas Hospital
University of Mississippi School of Medicine
University of Missouri Health Care
University of New Mexico School of Medicine
University of South Alabama College of Medicine
University of South Florida College of Medicine
University of Texas Health Center at Tyler
University of Texas Medical Branch Hospitals at Galveston
University of Virginia Medical Center
University of Washington Academic Medical Center
University of Wisconsin Hospital and Clinics
Vanderbilt University School of Medicine
Virginia Commonwealth University
Wake Forest University Baptist Medical Center
Washington Hospital Center
Washington University School of Medicine
West Virginia University Hospitals, Inc.
Yale-New Haven Hospital

Summary – Health Reform Preparedness



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Hype, Hysteria, or Coming Reality….?

http://www.youtube.com/profile?user=centurahealth#p/u/10/IF8bK7AJyL0

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….Combined With a Leap of Logic?

Today

- FFS
- Volumes
- 'All Things to All People'

…. across all mission fronts

In Between

1. Link Vision→Strategy→Focus
2. Multi-mission integrated budgets
3. Funds flow redesign
4. Core process redesign & reduce cost base
5. Care management capabilities
6. Continuum-of-care linkages
7. Multi-mission education redesign
8. HSR research focus
9. IT-enablement
10. Leadership development
11. Comp & incentive redesign
12. Employee health redesign
13. etc.

Tomorrow

- ACOs
- HIZs
- Populations
- Bundling
- Capitation

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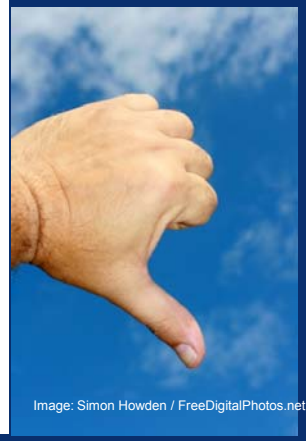
Phenomena #1

Moody's Outlook on Providers, Payers, and Universities is *Negative for the First Time Ever*



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Phenomenon #2

What Americans want from the Healthcare system:*

- We want the best care;
- We want it immediately;
- We want the most advanced drugs and technology;
- We want someone else to pay the bill; and…
- …if anything goes wrong, we want to sue someone.

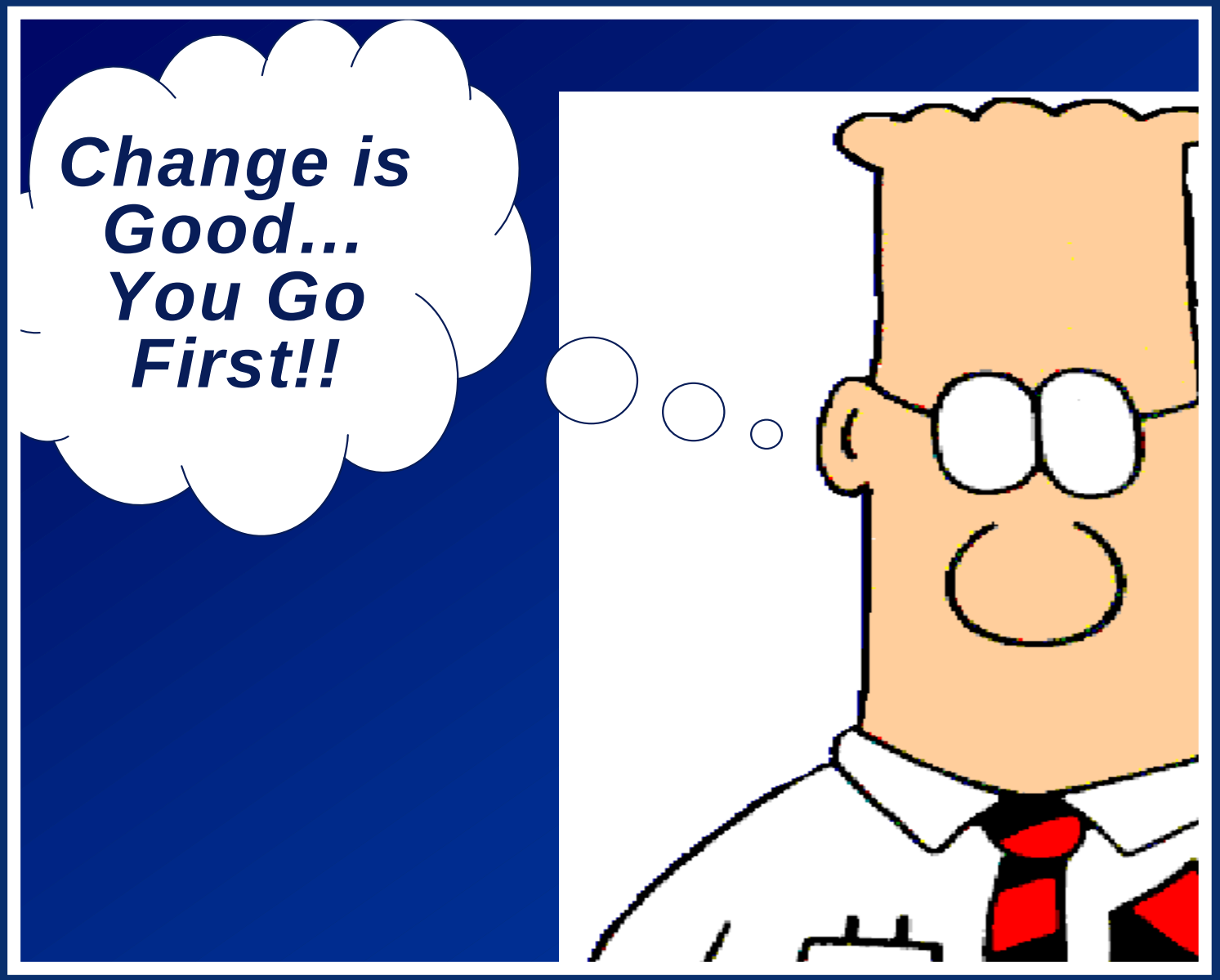
AND

We don't want to change any of our lifestyle choices and habits, even when we know our health suffers and costs rise because of them.

We want to live as long as possible, regardless of the cost or the quality of the extended life we get.

*** Tom Gorrie , Johnson & Johnson**

Phenomenon #3



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So What Are The Options?

Option 1: Continue an aggressive “whack-a-mole” strategy.

Option 2: Hold on until it’s someone else’s problem.

Option 3: When faced with a health benefits crisis, do what other industries do… outsource.

Option 4: Create a transformational initiative that meets the challenges simultaneously!

(particularly if you are a large self-insured employer, who is also a provider, a researcher, and an educator)

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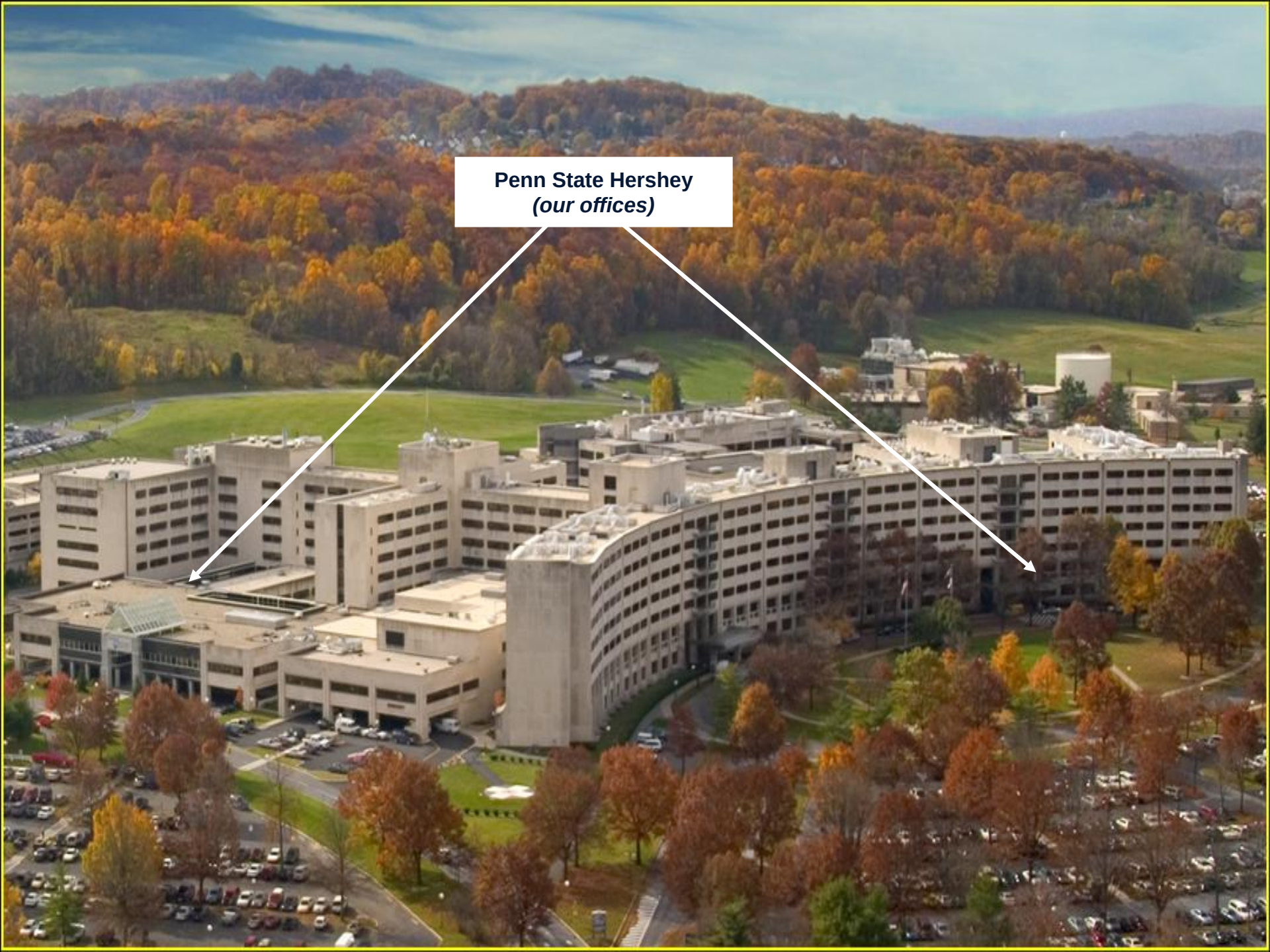
Penn State Hershey
(our offices)

“Rather than telling the rest of the world they need to change, how about we transform healthcare for ourselves?”

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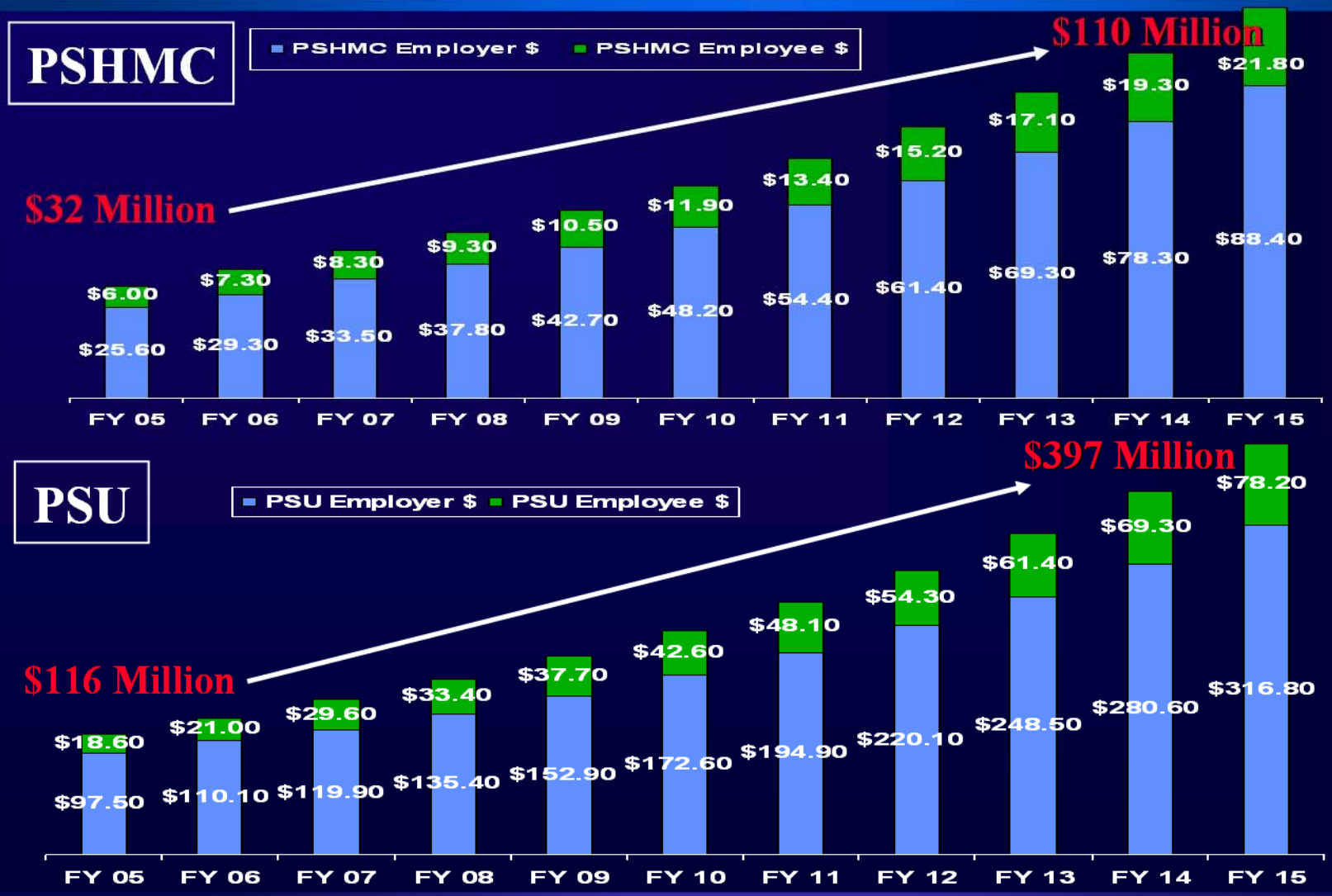
The Future . . .if we do nothing



10 Yr Total

$700 Million

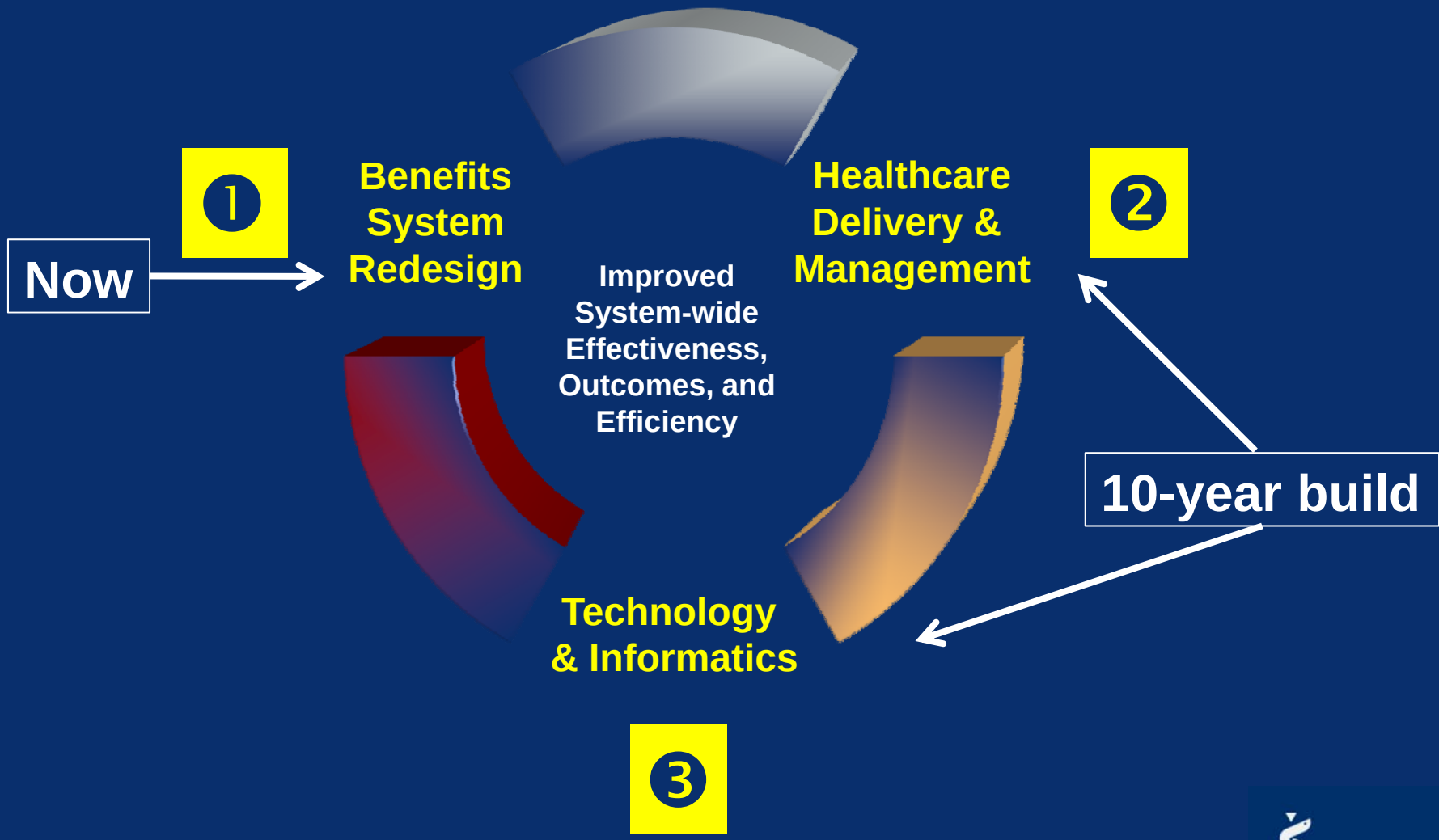
10 Yr Total (in billions)

$2.4 Billion

$3.1 Billion

PENNSTATE
Milton S. Hershey Medical Center
College of Medicine

New Healthcare Model for Central PA



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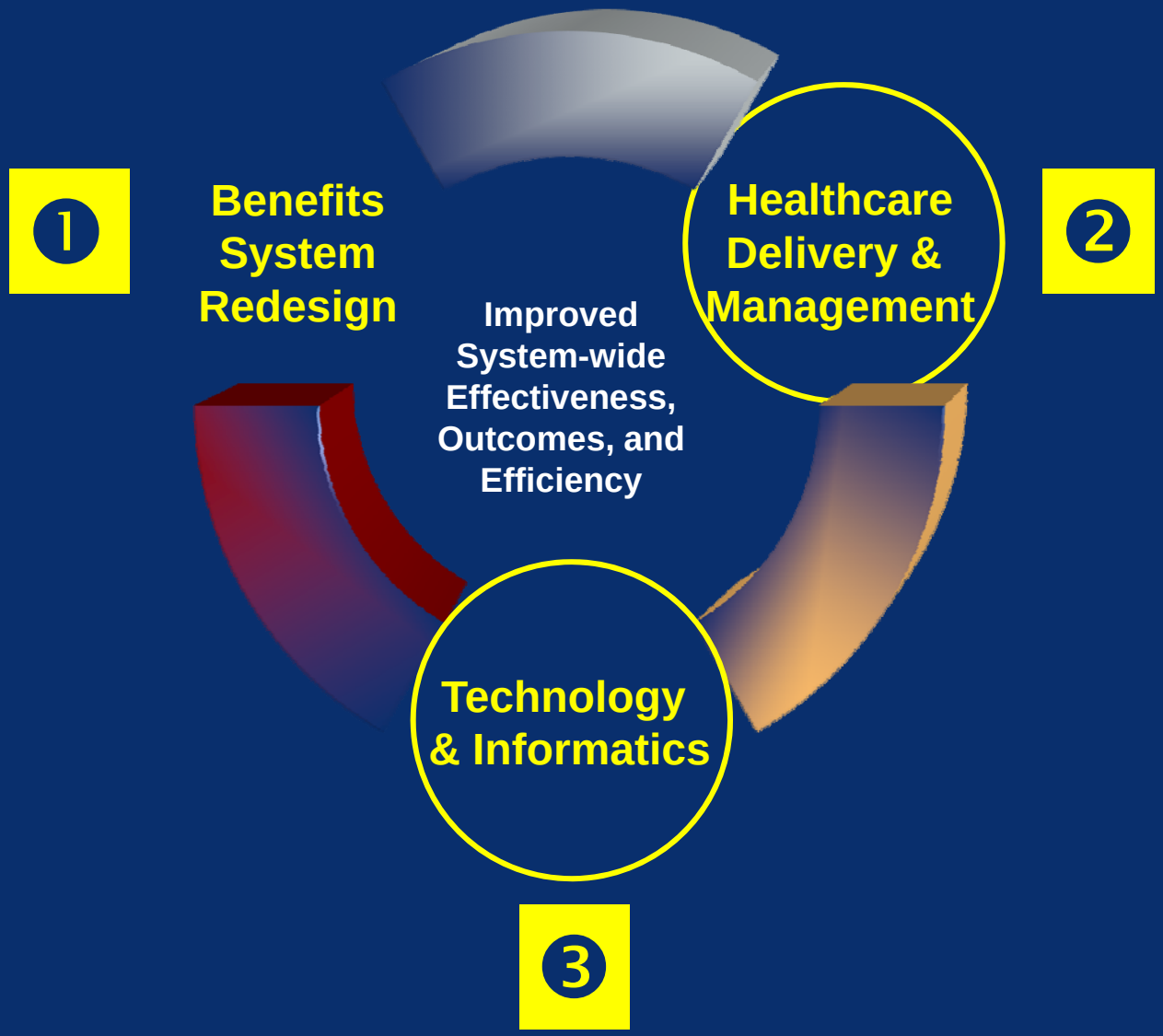
New Healthcare Model for Central PA



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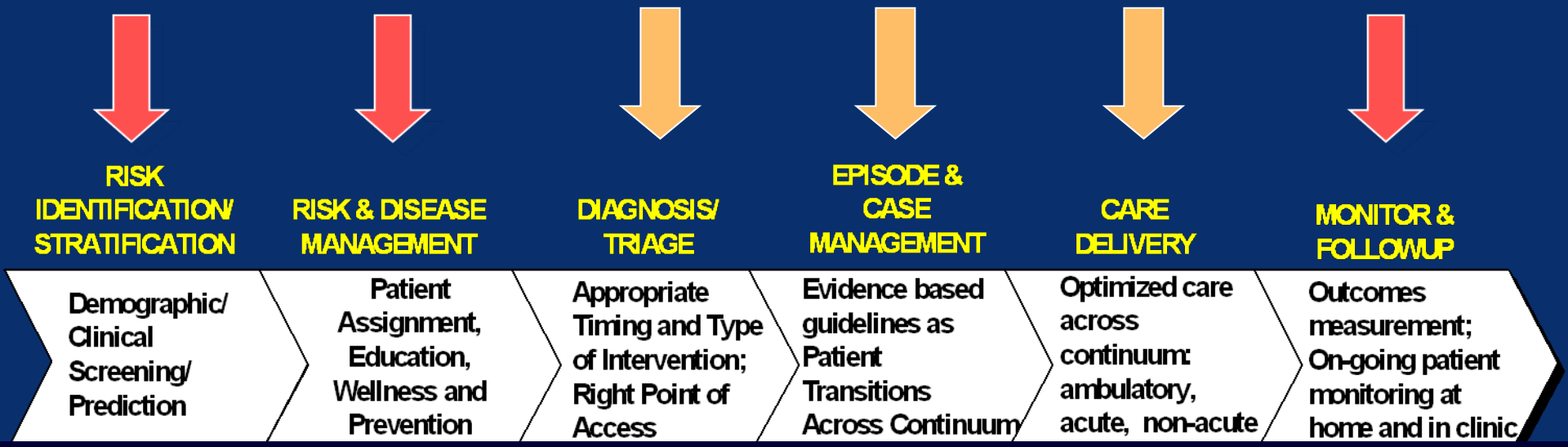
A New Care Delivery Model



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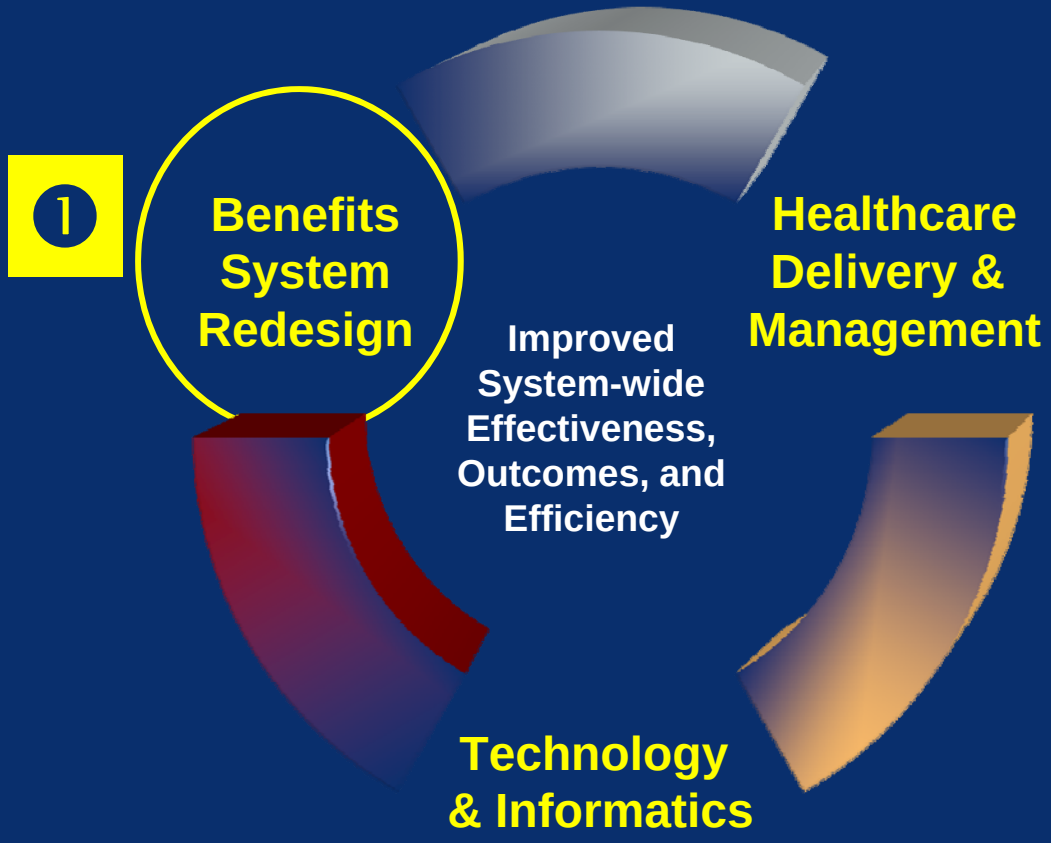
New Healthcare Model for Central PA



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Healthcare Benefits Pop Quiz !!

1. My monthly or yearly premium deduction is….?
2. What % of my salary does premium represent?
3. The monthly or yearly premium portion that the Medical Center pays is…?
4. My annual deductible is….?
5. My co-pay for primary care visits is…? specialty visits is…?
6. My annual "out of pocket maximum" is…?
7. I know what a Health Reimbursement Account (HRA) is…?
8. I have read and have signed an:
   - organ donor card?
   - advance directive and living will?
9. I know both what "BMI" is and I know what my BMI is?
10. I know the greatest risk(s) to my long –term health?

Medical Center Employees by Salary Level

Salary Range	# of Employees
< $25,000	888
25,000 to $49,999	3062
$50,000 to $74, 999	1016
$75,000 to $99,999	242
> $100,000+	461

88%

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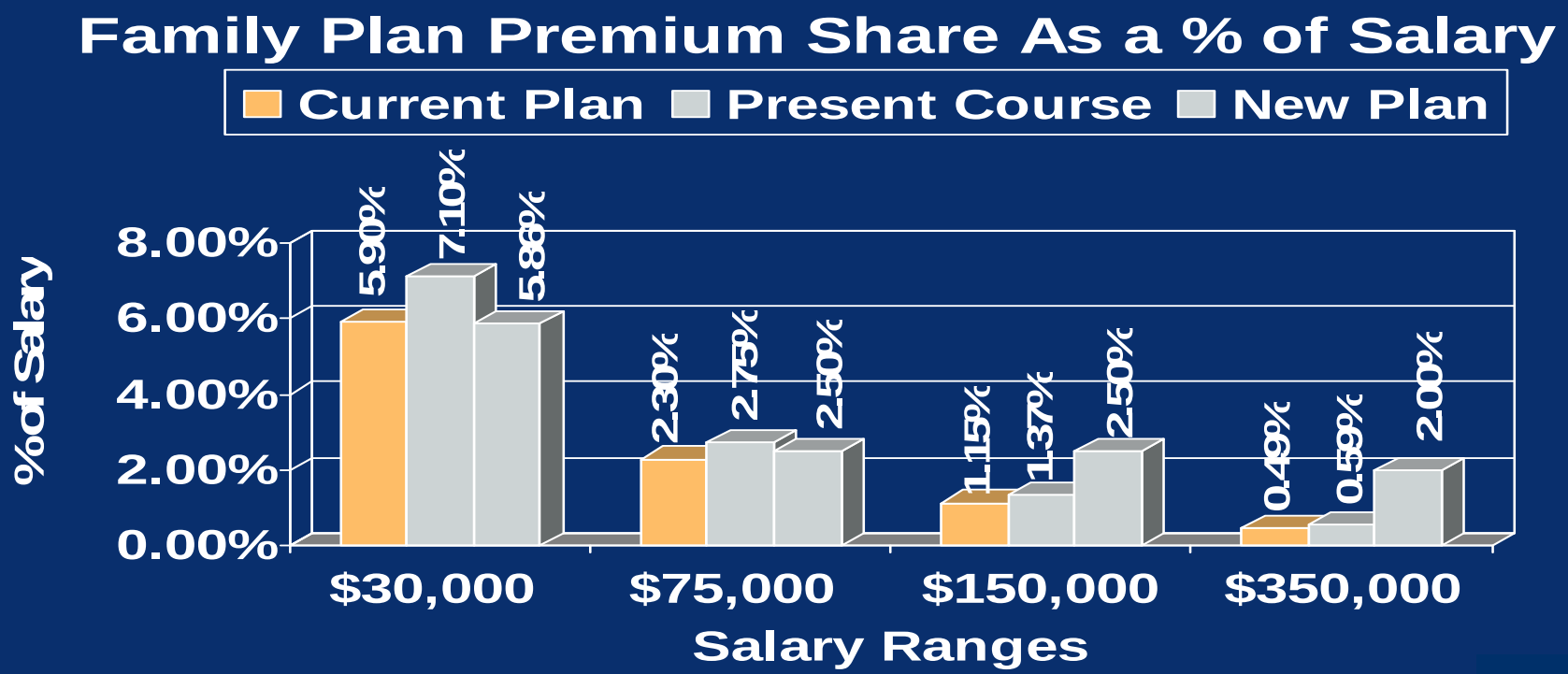
Employee Share of Healthcare Premium

	Biweekly	Monthly
Individual	$27.03	$58.57
Family	$66.37	$143.80



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Redesign of Employer's Health Benefits

- Only one plan was offered
- Introduced high deductibles
  (e.g., $3,000 family)
- Premiums reverse indexed by income
  (e.g., low income = $2,000/yr; high income = $7,000/yr)
- Employer-funded HRA component seeded against the deductible reverse indexed by income
  (e.g., low income = $2,250; high income = $400)
- Evidence-based, preventative care services, covered-in-full
- Incentives:
  - $0 co-pay for using employer facilities for expensive testing, procedures, hospitalization, specialty care
  - $200 for engaging in weight loss and 'stop smoking' initiatives
  - $100 for educating yourself in advance directives & arbitration
- Unspent HRA balances rolled forward each January 1 with new HRA investment added

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Redesign of Employer's Health Benefits

Annual Salary →	*< $70,000 Employee*	*>$289,000 Employee*
Annual Deductible	$3,000	$3,000
Annual HRA Contribution	$2,250	$400
Annual Premium	$2,000	$6,000

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Redesign of Employer's Health Benefits: *Campaign Mode*

- Town Hall meetings with 4,500 employees, staff, and faculty
- Trained up 200 managers to answer FAQs
- Extended longer, hands-on, open enrollment period
- Transparent pricing and comparison shopping
  - Comparison data for assessing our new plan against external plans
  - Intranet website for internal price comparators for procedures & visits
  - HR Help Line to answer employee's questions
  - Clinic "cheatsheets" and physician education to answer employee's questions
- Forged an exclusive, long term, single payer agreement for low cost ASO and web portal services; incentive terms for maintaining top quartile cost & real quality outcomes

Redesign of Employer's Health Benefits: *Results*

- **First year results**
  - Garnered SEIU and Teamster support
  - Highest ever enrollment (96%)
  - 25% reduction against predicted budget
  - 13% reduction against prior year actuals
  - 40% of seeded HRA dollars savings rolled over
- **Multi-year trend**
  - Removed over $6M of costs per year from the projected course and speed
  - Employee satisfaction results equal or better

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Redesign of Employer's Health Benefits: *Physician Engagement & Impacts…*

- **As Care Givers…**
  - Discomfort of employee's questioning the need for testing
  - Exposed the knowledge gap between 'value' and 'cost'
  - Established real preventative services that matter

- **As Leaders…**
  - A shift from the sidelines into the actual field of play
  - Employee engagement in real time decisions and choices

- **As Individuals…**
  - Exposed the philosophical clashes
    - *Democratic & Republican leanings*
    - *Leading reform & funding one's back pocket*

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Redesign of Employer's Health Benefits: *Yet to be Accomplished*

- Crack the code on chronic disease
- Resolve whether punitive measures are required
- Find other leading-edge employers to implement with

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Summary Points

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Tomorrow's Doctors, Tomorrow's Cures

Learn
Serve
Lead

1. Change is coming…
2. …and you can be at the effect of it or you can be the cause of it.
3. It's up to you.

   You have the opportunity to choose to lead.

Association of American Medical Colleges

Patriot 2-19-06

HEALTH CARE

Remedy sought for insurance woes

Medical center tests cost-sharing strategy

BY DAVID WENNER
Of The Patriot-News

Penn State Milton S. Hershey Medical Center is no longer limited to battling disease. It has begun testing a cure for what many regard as the biggest threat to health care: out-of-control costs.

The experiment is based on the increasingly popular concept that people must take greater responsibility for their health care, including footing more of the bill. But it has unique features, including a lower level of cost sharing for lower-paid employees and a higher level for those at the top of the income ladder.

That makes it a bitter pill to swallow for some of the medical center's doctors and other high earners, who now are charged more for their health care.

On Jan. 1, the medical center's 7,000 employees were shifted into high-deductible health insurance plans combined with health reimbursement arrangements, known as HRAs.

The employees previously paid part of their health insurance premiums but had low deductibles and co-payments. Now they face annual deductibles of at least $1,000 and significant co-payments.

To help with those costs, the medical center contributes money to the HRAs. HRA contributions vary based on income, with the largest amounts going to those who earn the least.

Dr. Darrell Kirch, CEO of the medical center, said a drastic change in

Please see PLAN on Page C9

PLAN: Medical center seeks cure for health care costs

Continued from Page C1

health benefits is the only way to prevent the medical center from eventually collapsing under the weight of the health care costs of its employees.

The medical center's position as a payer of employees' medical expenses, as well as the provider of those medical services, makes it a unique "laboratory" for developing a solution to the cost crisis, he said.

The cost of health care for medical center employees was $32 million in 2005, with the medical center paying $26 million and employees paying $6 million, Kirch said.

If spending would continue unchecked, he said, the cost would reach $110 million in 2015, with the medical center paying $88 million and employees paying $22 million. Neither employer nor employee could withstand such costs, Kirch said.

Kirch believes the root of the cost explosion is the expectation of receiving the best possible care while bearing little of the cost.

During months of meetings with employees to discuss the health plan, Kirch said, he and other executives were shocked by employees' "disconnect" with details of their health benefits.

Employees knew details of their auto insurance, said David Hefner, chief operating officer. But they knew little about their health insurance and the actual cost of their health care, and they were similarly uninformed about details of their health, such as their blood pressure and cholesterol levels.

"We sat there and said how did we get so disconnected?" Kirch said.

The theory behind Penn State-Hershey's approach is

KIRCH

HEFNER

that costs can be reduced by establishing a strong connection between the health care people use and the cost of that care, and between employees' personal health and the lifestyle choices that affect it.

The plan encourages preventive care and healthy lifestyles, requiring minimal copayments for preventive care. It gives extra HRA contributions for healthy-living practices, such as quitting smoking or participating in a walking program, and even for learning about important health topics.

It also attempts to impact major cost drivers, such as end-of-life care and medical malpractice. Employees can earn extra HRA contributions by reviewing educational materials regarding advance directives and the use of arbitration rather than malpractice lawsuits.

So-called "consumer-directed" health care, typically involving HRAs or the closely-related health savings accounts, are widely promoted as a way to get people to spend more wisely on health care.

Yet Kirch said consumer-directed health care often amounts to "cost-shifting" of health expenses to the employee.

He contends people with lower incomes are unlikely to adequately fund an HSA and would be driven to avoid primary and preventive care.

With that in mind, Penn State-Hershey sought to ensure that lower-paid employees don't end up with less access to medical care.

Hefner has no estimates on how much money the medical center will save. The plan represents a long-term approach and it will take years to measure the impact, he said.

The plan has the greatest financial affect on the medical center's highest earners. Hefner, the No. 2 executive at the center, said he shopped for family insurance coverage before deciding to stick with the medical center's plan.

The medical center has 461 employers who earn $100,000 or more, with most doctors earning more than $100,000 a year.

As an example, an employee who earns $150,000 now pays $306.25 per month for family coverage — about twice as much as before. The medical center puts $670 per year in that employee's HRA — well below the $2,050 contribution it makes to someone who earns $75,000 or less.

Doctors at the medical center met several times late last year to discuss what they viewed as deteriorating benefits and privileges, and the health plan was commonly cited as an example.

The Service Employees International Union, which represents 1,000 registered nurses at the medical center, supports the plan, and nurses pay slightly lower premiums than before, said Neil Bisno, a union official.

Bisno stressed that the SEIU supports national reforms to make health care affordable for all workers. But he said the medical center is sincere in its desire to use prevention to make health care affordable and to ensure quality care for people of all incomes.

"This particular employer is trying to take some creative steps [to solve the health care crisis], and our members have decided to work with the employer to address those challenges together," he said.

The SEIU also likes the HRA, because it provides an opportunity to save for post-retirement medical expenses, Bisno noted.

"It's a whole different way of looking at how you approach health care for you and your family. I think pretty many people are fairly happy with it," said Jamie Coleman, a registered nurse at the medical center.

Kirch said the United States has failed to adequately address the health care crisis, and it may be too late.

But he believes its makes sense for an academic medical center to provide a solution, and he holds out hope the Penn State-Hershey experiment can turn into a model for other employers.

"The health care system is going to decide what the next decade is like in this country," he said.

DAVID WENNER: 255-8172
or dwenner@patriot-news.com

Acceptance of options takes time

So-called consumer-driven health plans based on HSAs and HRAs have been slow to catch on.

A survey released in November by Mercer Health and Benefits found they were offered by 22 percent of large companies and 2 percent of small businesses. All told, 1 percent of workers were enrolled in such plans in 2005.

Kevin Erb of Conrad Siegel Actuary, a health-benefits consultant, regards the Penn State-Hershey plan as unusual because of the greater HRA contribution to workers with lower incomes.

"I think that's a very unique and a good approach," said Erb, a vice president with the Susquehanna Twp.-based firm.

A recent survey by the Employee Benefit Research Institute found people in HSA- and HRA-based plans were much more likely to avoid or skip health care because of cost, especially if they earn less than $50,000. It also concluded that people in such plans were making cost-conscious decisions, but they found it difficult to obtain information needed for such decisions.

The Penn State-Hershey plan offers a resource for employees to find out how much procedures cost.

Bob Whalen, an analyst with Mercer, disagrees that people in consumer-directed plans are avoiding care. He said the plans are causing a reduction in unnecessary care, but they are providing an incentive to take better care of chronic conditions such as diabetes.

"It's about reducing the use of some things, but increasing the use of other things that are more important," he said.

He said Mercer, a national firm, has about 250 clients that offer HSA- or HRA-based plans.

DAVID WENNER / The Patriot-News

PLAN AT A GLANCE

HERE ARE SOME basic details about the new health plan at Penn State Milton S. Hershey Medical Center:

- **It costs $985.25 per month** to provide high-deductible coverage for a family in 2006, the medical center said.
- **The portion of that amount** paid by the employee varies by income. For example, someone who earns less than $75,000 a year pays $142.86 per month for family coverage. Someone who earns $150,000 pays $306.25.
- **The annual deductible** — the amount the employee must pay before insurance kicks in — is $3,000 for family coverage. However, the deductible is $6,000 for services from providers not owned by Penn State-Hershey or not within the Capital Blue Cross provider network.
- **Employees get a health reimbursement** arrangement, or HRA, to help pay deductibles and co-payments. The medical center puts $2,050 into the HRA of someone with family coverage who earns less than $75,000. It puts $670 into the HRA of someone who earns more than $150,000.
- **Employees can earn $100** for their HRA by completing a health and wellness profile, and they can get another $100 by reviewing information about blood and organ donation, medical liability and end-of-life issues.
- **An HRA is an Internal Revenue Service-approved way** for an employer to contribute pre-tax money toward employee health care. Employees can't contribute to the HRA. The Penn State-Hershey HRA becomes vested after five years. Employees can't take their HRAs with them if they leave, but they can continue to bill it for medical expenses until it's depleted. HRAs are slightly different than health savings accounts, or HSAs, which allow the employer and the employee to save pre-tax dollars for health care. HSAs are portable, meaning employees can take them with them when they leave a job.
- **Penn State-Hershey is self-insured.** Its health plan is administered by Capital Blue Cross.