PRINCETON CONFERENCE

May 20, 2009

FIRST QUESTION

Is Stuart Altman really a Fascist?

The right-wing blogosphere has labeled him thus because he defends cost effectiveness analysis.

STUART, THE COMMIE *ProPAC* APPARATCHIK

WORKING UNDERCOVER

FINANCING HEALTH SERVICES

Uwe E. Reinhardt,

Princeton University

The 16th Annual Princeton Conference

"How Will We Meet the Health Service Needs of an Aging America?"

May 20-21, 2009

THE ASSIGNMENT TO OUR PANEL:

Session III: Financing health services: Current and Future trends

In the United States, we know that most people ultimately rely on Medicare and Medicaid for health services and long term care. Based on current CMS projections, the current financial model is not sustainable. What are the most reasonable options for financial reform? Are bundled payments the way of the future? Can we look to the private sector for help? What has the VA done and can we learn anything from their experience?

I. THE SUSTAINABILITY OF MEDICARE AND MEDICAID

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

The Long-Term Outlook for Health Care Spending

November, 2007

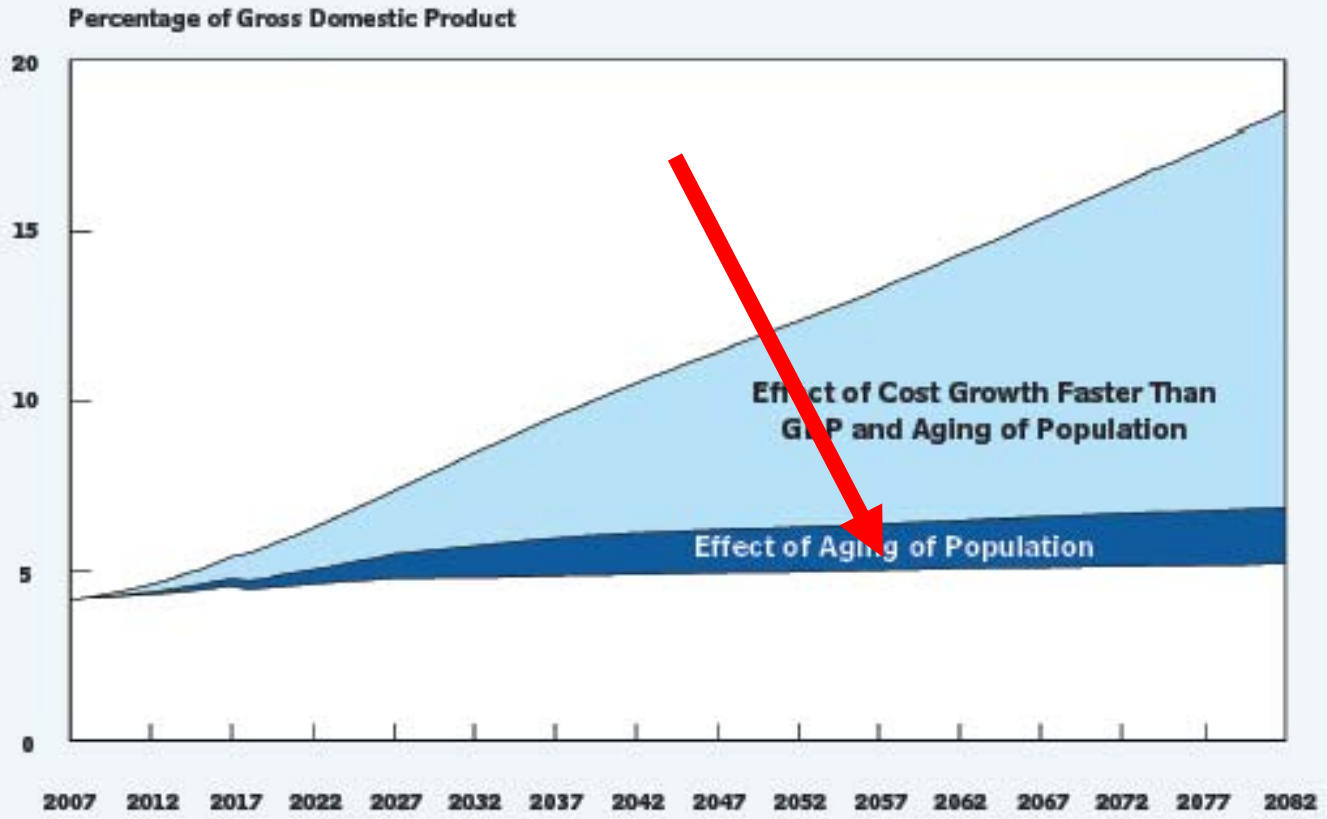
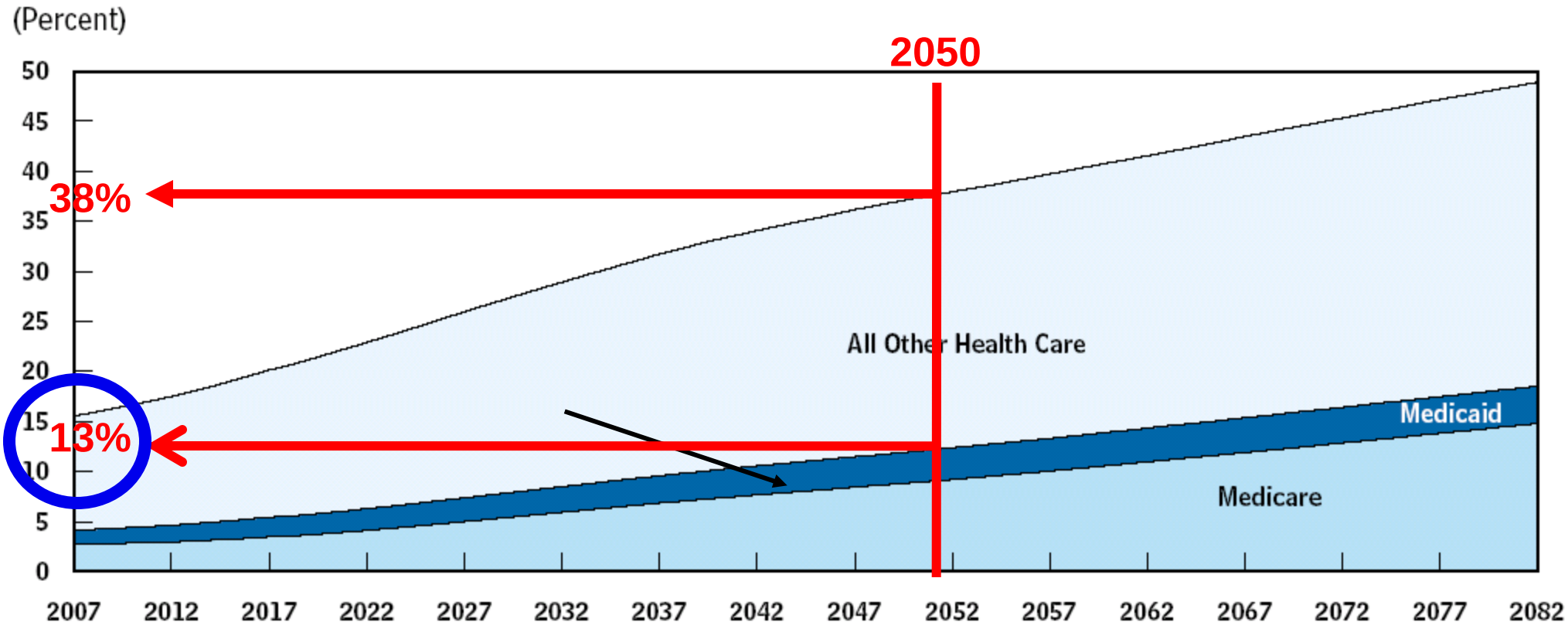


Figure 4.

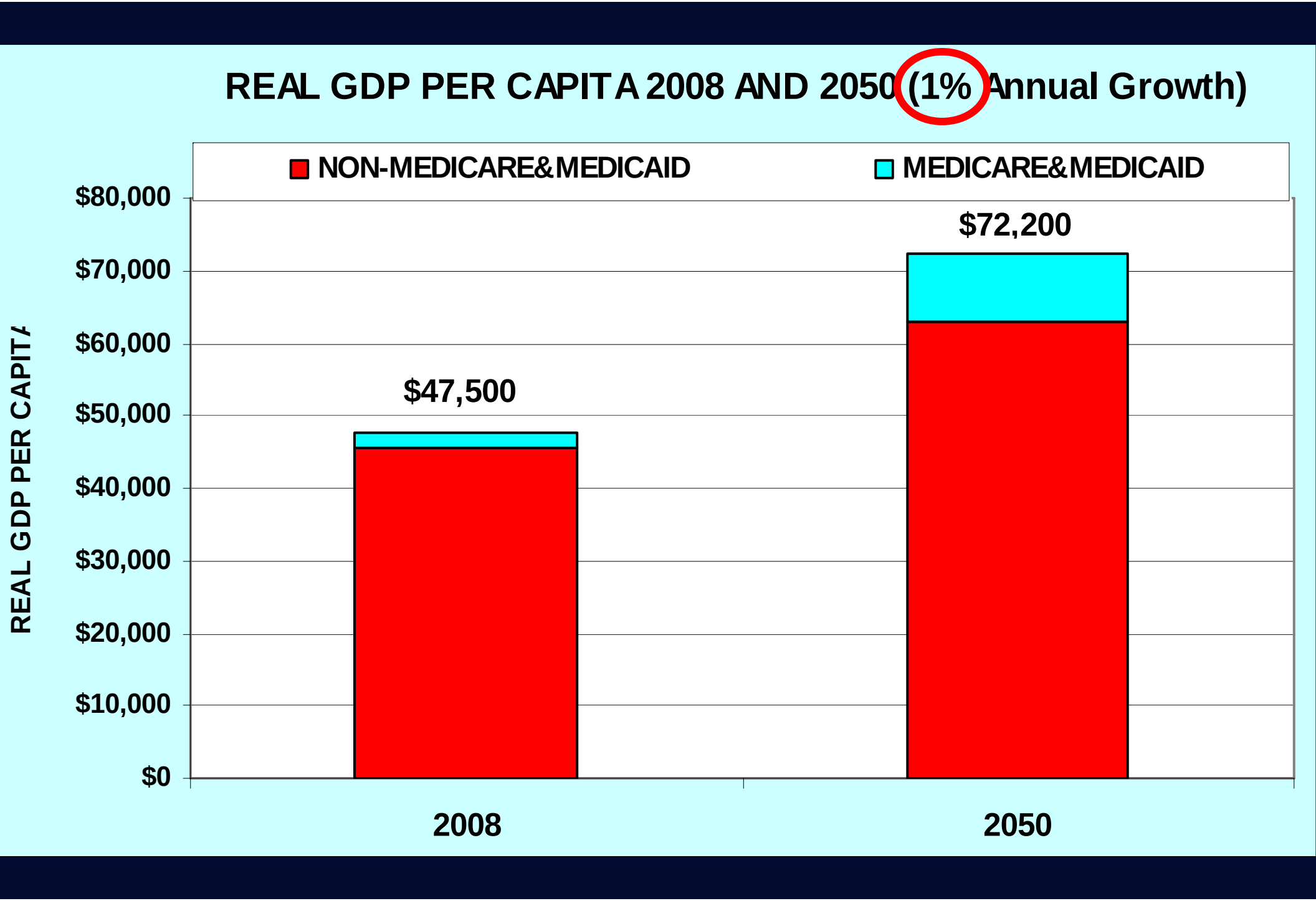
Projected Spending on Health Care as a Percentage of Gross Domestic Product



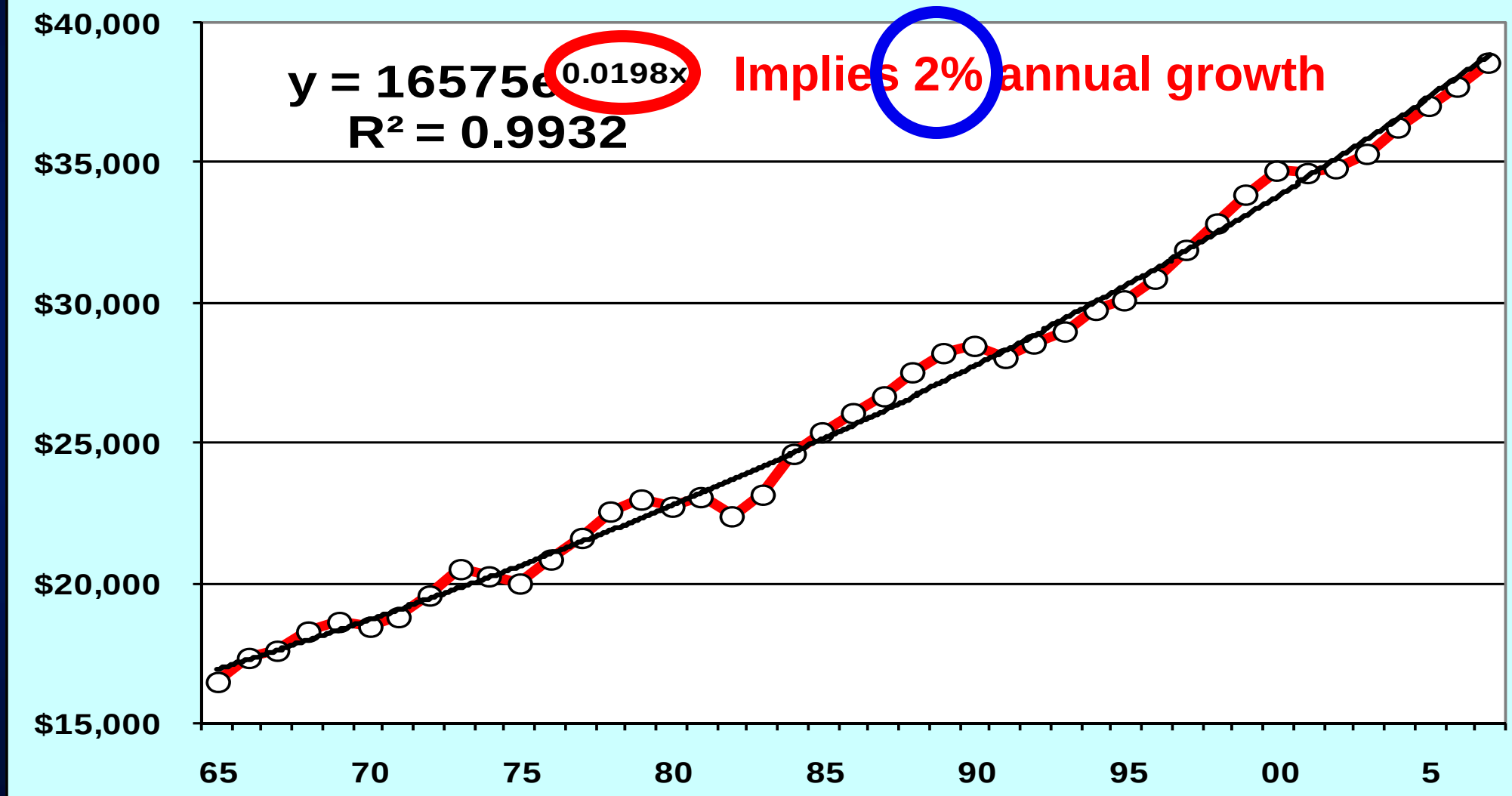
Source: Congressional Budget Office.

Note: Amounts for Medicare are net of beneficiaries' premiums. Amounts for Medicaid are federal spending only.

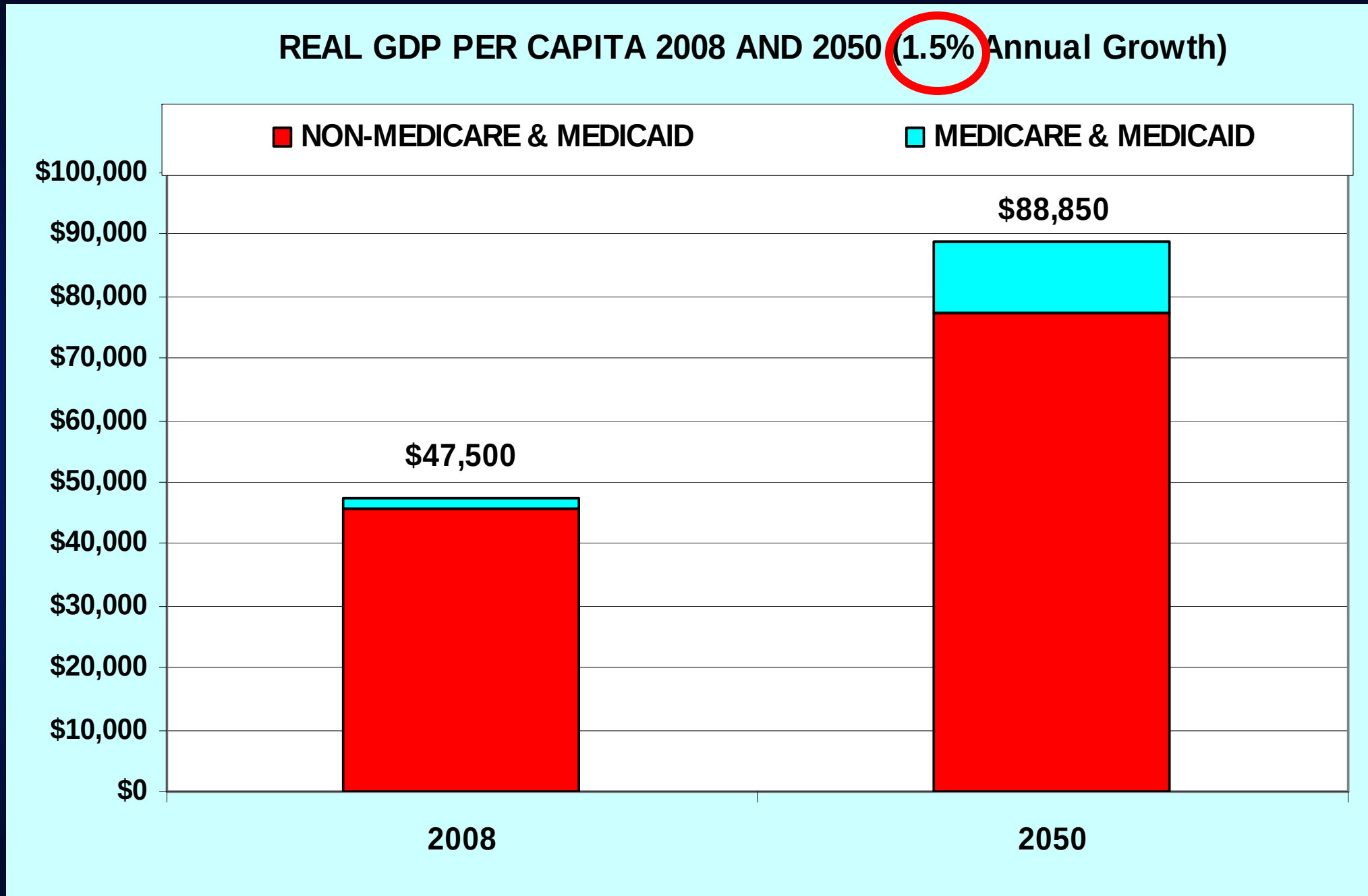
SOURCE: http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf


REAL GDP PER CAPITA 2008 AND 2050 (1% Annual Growth)
NON-MEDICARE&MEDICAID
MEDICARE&MEDICAID
REAL GDP PER CAPITA
$80,000
$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0
$47,500
$72,200
2008
2050

REAL GDP PER CAPITA 1965-2007



SOURCE: CMS Data & Statistics.


REAL GDP PER CAPITA 2008 AND 2050 (1.5% Annual Growth)
NON-MEDICARE & MEDICAID
MEDICARE & MEDICAID
$100,000
$90,000
$80,000
$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0
$47,500
$88,850
2008
2050

MY CONCLUSION

I take it that by “sustainability” we do not mean “economic sustainability” but “political sustainability”, that is, willingness to pay taxes to care for the health care of the elderly.

Or do we mean by “sustainability” that we cannot afford anymore the “overuse, misuse and fraud” we believe is rampant in US health care – for old and young?

The Business Roundtable **Health Care Value Comparability Study**

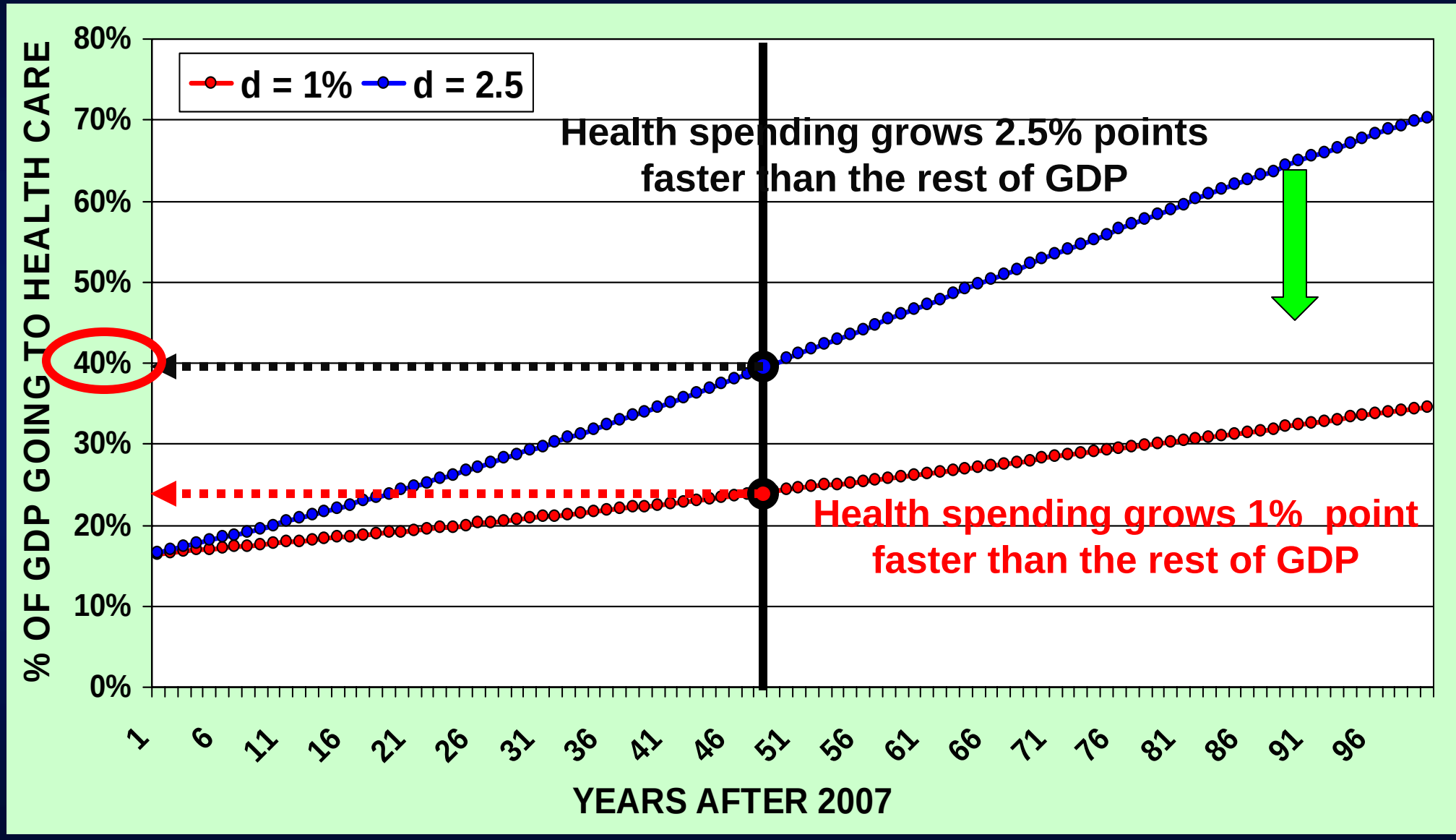
Executive Summary

Top-Line Findings:
A Substantial Health Care Value Gap

On a weighted scale, U.S. business faces a 23 percent "value gap" relative to five leading industrialized competitors – and a 46 percent "value gap" against three rising economic powers.

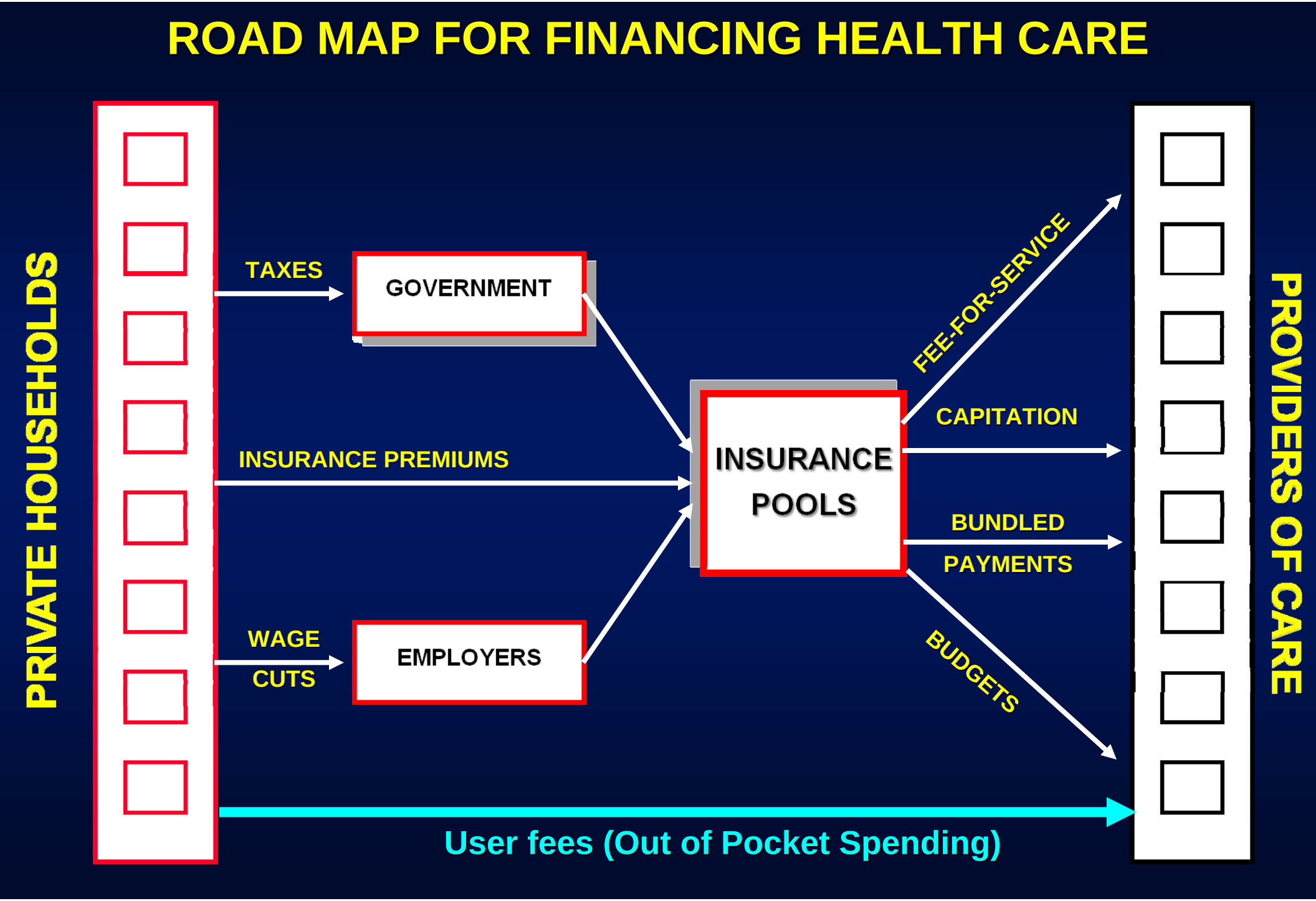
- Combining 19 internationally reported measures in a weighted scale that takes into account both the spending on, and performance of, our health care system, the United States stands at a 23 percent disadvantage relative to five leading economic competitors – Canada, Japan, Germany, the United Kingdom and France (the "G-5 group") – and a 46 percent disadvantage relative to the emerging competitors of Brazil, India and China (the "BIC group").

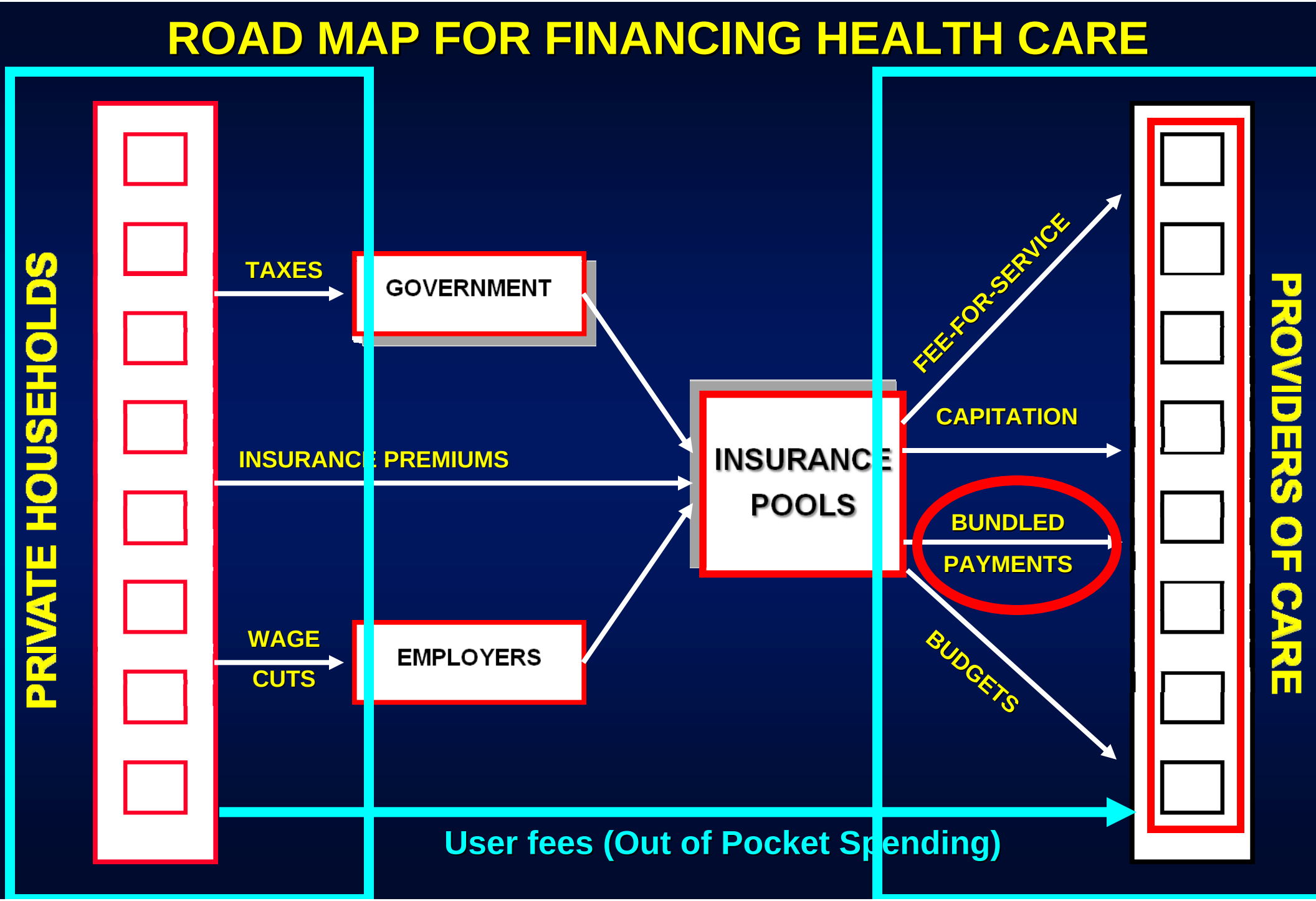
PROJECTED U.S. HEALTH SPENDING AS PERCENT OF GDP



Secretary of HHS David Petreaus

II. THE FINANCING OF HEALTH CARE


ROAD MAP FOR FINANCING HEALTH CARE
PRIVATE HOUSEHOLDS
TAXES
GOVERNMENT
INSURANCE PREMIUMS
WAGE
CUTS
EMPLOYERS
INSURANCE
POOLS
FEE-FOR-SERVICE
CAPITATION
BUNDLED
PAYMENTS
BUDGETS
PROVIDERS OF CARE
User fees (Out of Pocket Spending)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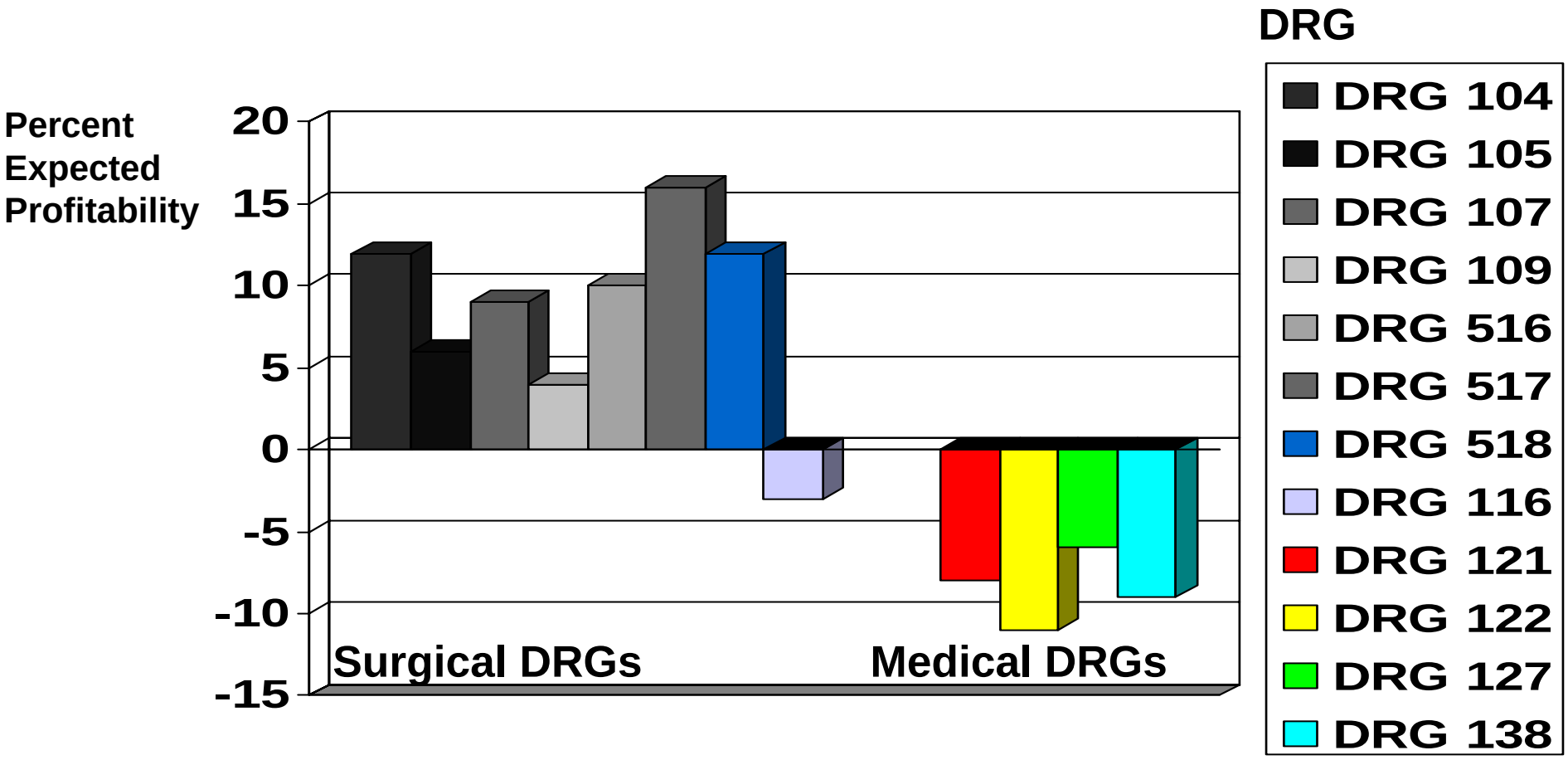
User fees (Out of Pocket Spending)

III. PAYING THE PROVIDERS OF HEALTH CARE

A. Medicare: the “big dumb price fixer.”

Relative Profitability across DRGs

Cardiac DRGs



Source: MedPAC

III. PAYING THE PROVIDERS OF HEALTH CARE

A. Medicare: the “big dumb price fixer.”

B. Private insurers: Smart price negotiators?

Table 6.3:

Large New Jersey Insurer's Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers – Minimum Cost Per Procedure versus Maximum Cost Per Procedure

Cost per Colonoscopy	In-Network Minimum to Maximum Range
Physician	$178 to $431
Hospital	$716 to $3,717
ASC	$443 to $1,395

Table 6.4:

Payments by a N.J. Insurer to Various Hospitals for Four Standards Services, 2007[47]

	Normal Delivery[1]	CABG[2]	Appendectomy[3]	Hip Replacement[4]
Hospital A	$2,178	$26,342	$2,708	$3,330
Hospital B	$2,787	$32,127	$2,852	$3,444
Hospital C	$2,906	$34,277	$3,320	$4,200
Hospital D	$3,187	$36,792	$3,412	$4,230
Hospital E	$3,276	$37,019	$3,524	$5,028
Hospital F	$3,629	$45,343	$4,230	$5,787

[1] Mother only, case rate.
[2] Coronary Bypass with Cardiac Catheterization (DRG 547), tertiary hospitals only.
[3] Surgical per diem (DRG 167) with average length of stay of 2 days
[4] Surgical per diem for Total Hip replacement, average length of stay 3 days.

Table 6.5:

Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

	Appendectomy[1]	CABG[2]
Hospital A	$1,800	$33,000
Hospital B	$2,900	$54,600
Hospital C	$4,700	$64,500
Hospital D	$9,500	$72,300
Hospital E	$13,700	$99,800

[1] Cost per case (DRG 167)

[2] Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.

III. PAYING THE PROVIDERS OF HEALTH CARE

A. Medicare: the “big dumb price fixer.”

B. Private insurers: Smart price negotiators?

B. The new panacea: Bundled payments

PROMETHEUS™ PAYMENT

Igniting Payment Reform

Provider payment Reform for Outcomes Margins Evidence Transparency Hassle-reduction Excellence Understandability and Sustainability

Rummaging through the Prometheus Payment® Inc. website quickly makes it clear that developing Evidence Based Case Reimbursement (ECRs) payments is a technically difficult as well as politically difficult.

Bundled payments are designed to trigger clinical integration of the delivery of care across ambulatory and inpatient sites.

But that implies a redistribution of cherished professional and economic privilege.

EXAMPLE

Bundling radiologists, anesthesiologists and pathologists (the RAPs) as well as convalescent care into the DRG payments to hospitals.

How easy would that be?

III. PAYING THE PROVIDERS OF HEALTH CARE

A. Medicare: the “big dumb price fixer.”

B. Private insurers: Smart price negotiators?

B. The new panacea: Bundled payments

C. Clinically Integrated Health Care

FROM A TALK GIVEN 15 YEARS AGO:

HEALTH "SYSTEMS" AS A SET OF SILOS

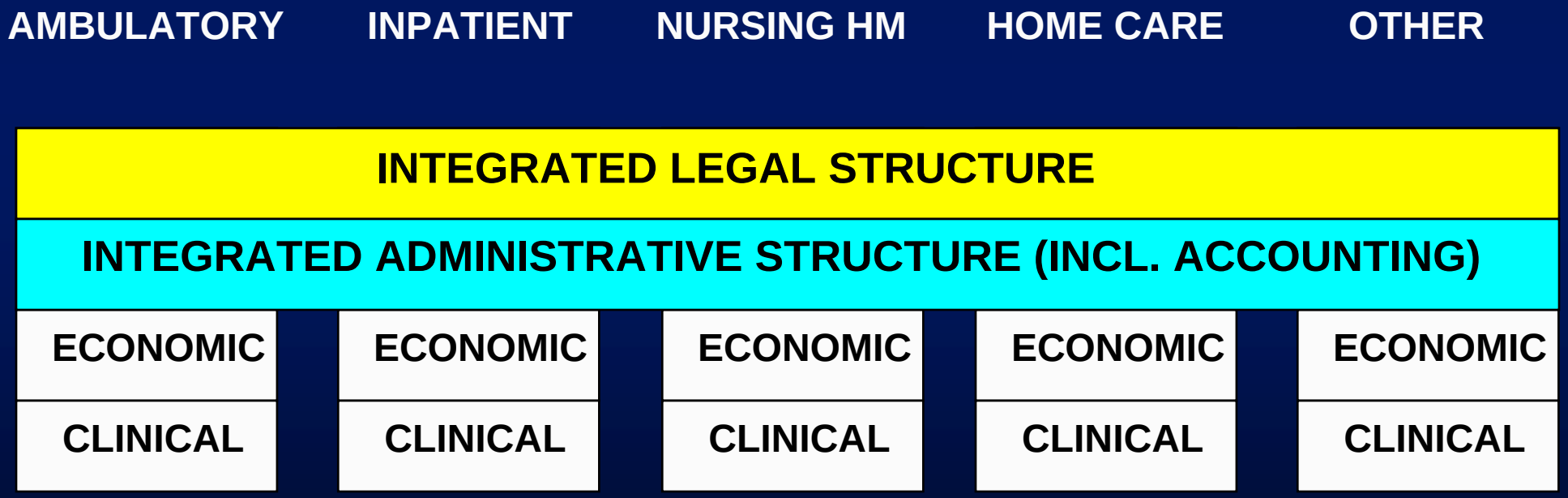
AMBULATORY	INPATIENT	NURSING HM HM	HOME CARE	OTHER
LEGAL	LEGAL	LEGAL	LEGAL	LEGAL
ADMIN.	ADMIN.	ADMIN.	ADMIN.	ADMIN.
ECONOMIC	ECONOMIC	ECONOMIC	ECONOMIC	ECONOMIC
CLINICAL	CLINICAL	CLINICAL	CLINICAL	CLINICAL

CONSOLIDATION JUST FOR THE FUN OF IT

AMBULATORY	INPATIENT	NURSING HM	HOME CARE	OTHER
INTEGRATED LEGAL STRUCTURE				
ADMIN.	ADMIN.	ADMIN.	ADMIN.	ADMIN.
ECONOMIC	ECONOMIC	ECONOMIC	ECONOMIC	ECONOMIC
CLINICAL	CLINICAL	CLINICAL	CLINICAL	CLINICAL

HARVESTING A LITTLE "SYNERGISM"

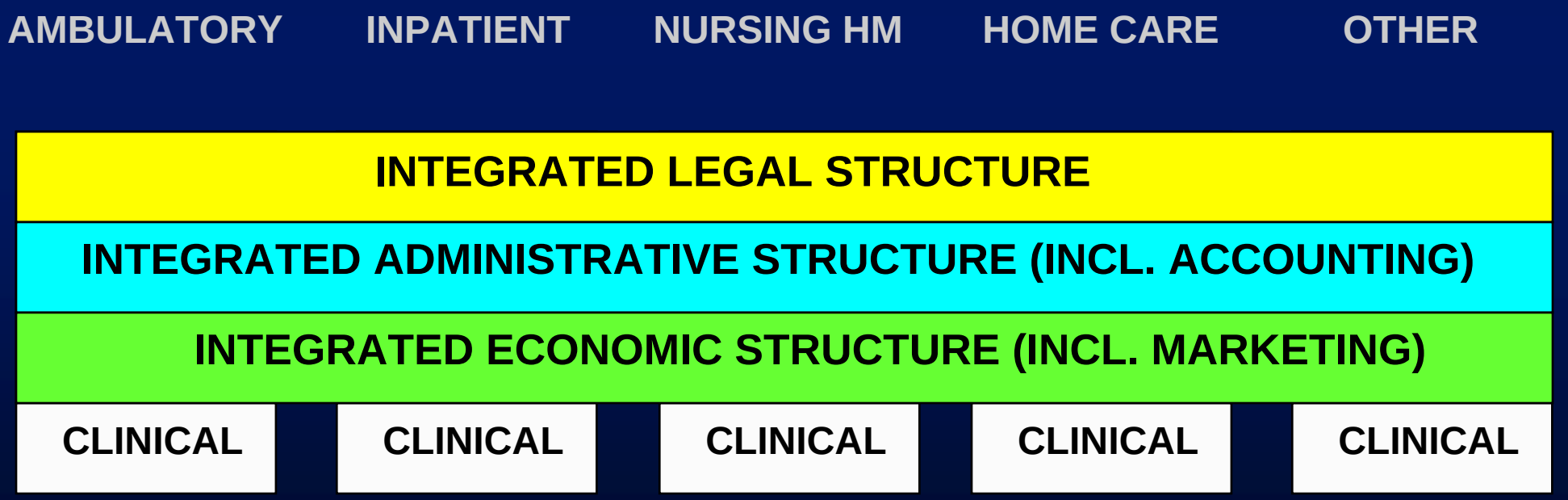
Firing a few hapless accountants



HARVESTING MORE SIGNIFICANT "SYNGERISM"

Eliminating duplicative clinical programs

Creating market muscle (monopoly power)



ATTEMPTING THE REAL McCOY:

Genuine, patient-focused clinical integration

So far this is mainly a blueprint.

AMBULATORY INPATIENT NURSING HM HOME CARE OTHER

INTEGRATED LEGAL STRUCTURE
INTEGRATED ADMINISTRATIVE STRUCTURE (INCL. ACCOUNTING)
INTEGRATED ECONOMIC STRUCTURE (INCL. MARKETING)
GENUINE, PATIENT- FOCUSED CLINICAL INTEGRATION

III. PAYING THE PROVIDERS OF HEALTH CARE

A. Medicare: the “big dumb price fixer.”

B. Private insurers: Smart price negotiators?

B. The new panacea: Bundled payments

C. Clinically Integrated Health Care

D. A Modest Proposal

A MODEST PROPOSAL

1. Require that hospitals use the DRG system as a relative value scale for all patients.
2. Allow hospitals to set their own conversion ratios.
3. Require hospitals to charge the same fees to all payers.
4. Start bundling in the RAPs and convalescent care.
5. With most of inpatient care bundled in this way, expand the system to embrace more and more of care in other setting.

If you think this would be politically too difficult, what makes you think imposing bundled payments on the American health system – that collection of separate fiefdoms -- would be any easier?

Mazel tov!