Healthcare Costs and Payment Models

To the moon and back!

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Learning Objectives

Upon completion of this session, participants will improve their competence and performance by being able to:

2. Discuss trends and projections for costs of care.
3. Describe some of the payment models designed to reign in healthcare spending.
4. Discuss current issues that drive national discussions.
Meet Jesus and Olivia

- Married many years – immigrated to Oklahoma from Mexico more twenty years ago
- Both work full time doing custodial services – both are uninsured
- Olivia referred for uncontrolled diabetes
  - HbA1c > 10
  - Very early diabetic kidney disease
  - Mild hypertension
- Jesus recently hospitalized with a small stroke – some residual weakness of his left hand
  - Hypertension and hyperlipidemia
Spending on health care reached $3.4 trillion in 2016 and is expected to rise, report says.

Health spending grew 4.8 percent in 2016, slightly less than the year before when it rose 5.8 percent. However, don't expect the expenditures to stall for long, the report found. They could account for nearly 20 percent of U.S. spending by 2025.

National Health Expenditures - 2018

• Grew 4.6% to $3.6 trillion in 2018
  • $11,172 for every person in the United States
  • 17.7% of the GDP

• Spending by payer type
  • Medicare – grew 6.4% to $750.2 billion
  • Medicaid – grew 3.0% to $597.4 billion
  • Private health insurance – grew 5.8% to $1.24 trillion
  • Out of pocket spending – grew 2.8% to $375.6 billion
Where do we spend the money?

• Hospitals - $1.2 trillion in 2018 (a 4.5% increase)
  • Accelerated price growth with slower growth in the use and intensity of services

• Physicians and clinical services - $725.6 billion in 2018 (a 4.1% increase)

• Retail prescription drug spending - $335 billion (a 2.5% increase)

U.S. Sources of Healthcare Coverage 2019 (Millions)

Population 330*

Medicare (Age 65+)
  ~59

Non-Institutional Under 65
  273

Military
  ~12

Employer Based
  159

Other Coverage
  84*

Uninsured
  30

Medicaid & CHIP
  57

ACA Medicaid & ACA Basic
  13

Nongroup ACA Exchange
  9

Other Nongroup
  5

Other**
  11

*Note: Sum does not equal detail due to individuals with multiple types of coverage. Medicare assumes 2018 figure +1m. Military from 2018.
**Other includes Medicare disability under age 65 (8m) and 3m other

Sources:
Report: U.S. healthcare spending to grow 4% in 2019

by Tina Reed | May 29, 2019 7:15am
Hospital expenses are the largest category of Medicare spending, but their share has fallen over time.

Composition of Medicare Payments (% of Total Medicare Spending)

SOURCE: Centers for Medicare and Medicaid Services, National Health Expenditures, December 2014. Compiled by PGPF.
NOTE: All data for 2014 are projected.

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PGPF.ORG
Health Expenditures by Spending Category

- Physician, clinical, dental and other professional services
- Hospital care
- Investment
- Net cost of health insurance
- Government administration and public health activity
- Prescription drugs
- Other retail outlet sales of medical products
- Nursing care and continuing care retirement communities
- Home health care
- Other health, residential and personal care

Fig. 2: Historical and Projected Federal Health Care Spending (Percent of GDP)

Source: Office of Management and Budget, Congressional Budget Office, CRFB calculations.
National Health Expenditures by Source of Funds

Medicare spending is a growing share of the federal budget

Pie charts showing the percentage of spending in 1970, 2014, and 2040, with categories including Medicare, Medicaid, Social Security, Other Programs, and Net Interest.

Prices are Driving the Largest Part of Growth in Costs

Factors accounting for growth in personal health care expenditures, selected calendar years 1990–2025

How many dollars stacked to reach moon?
Healthcare Expenditures in Perspective

• The estimate:
  • The Moon is an average of 384,403 km from Earth.
  • That is 384,403,000 meters (384 million meters)
  • That is 384,403,000,000 millimeters (384 billion)
  • If the thickness of a US Dollar is about 1 millimeter,
    that means you could stack 384 billion dollars to the moon.
  • $3.6 trillion / $384 billion = > 9 times to the moon
    .......More times than NASA landed on the moon.
We spend a lot of money, but we get great health outcomes.....  ..right?
Health Care Spending as a Percent of GDP, 1980–2017

Adjusted for Differences in Cost of Living

Percent (%) of GDP

Notes: Current expenditures on health per capita, adjusted for current US$ purchasing power parities (PPPs). Based on System of Health Accounts methodology, with some differences between country methodologies (Data for Australia uses narrower definition for long-term care spending than other countries). *2017 data are provisional or estimated.

Source: OECD Health Data 2018.
Life Expectancy at Birth and Health Spending Per Capita (2015 or latest year)

Source Data: OECD.Stat

OECD Statistical Database using 2015 data.
Life expectancy vs. health expenditure, 1970 to 2015

Health financing is reported as the annual per capita health expenditure and is adjusted for inflation and price level differences between countries (measured in 2010 international dollars).

OurWorldInData.org/the-link-between-life-expectancy-and-health-spending-us-focus • CC BY

https://ourworldindata.org/grapheur/life-expectancy-vs-health-expenditure
The U.S. has the lowest life expectancy at birth among comparable countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Life Expectancy at Birth in Years, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>84.2</td>
</tr>
<tr>
<td>Switzerland</td>
<td>83.6</td>
</tr>
<tr>
<td>Australia</td>
<td>82.6</td>
</tr>
<tr>
<td>France</td>
<td>82.6</td>
</tr>
<tr>
<td>Sweden</td>
<td>82.5</td>
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<tr>
<td>Comparable Country Average</td>
<td>82.3</td>
</tr>
<tr>
<td>Canada</td>
<td>82.0</td>
</tr>
<tr>
<td>Netherlands</td>
<td>81.8</td>
</tr>
<tr>
<td>Austria</td>
<td>81.7</td>
</tr>
<tr>
<td>Belgium</td>
<td>81.6</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>81.3</td>
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<tr>
<td>Germany</td>
<td>81.1</td>
</tr>
<tr>
<td>United States</td>
<td>78.6</td>
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</table>

Source: KFF analysis of OECD data • Get the data • PNG
## Exhibit 2. Health Care System Performance Rankings

<table>
<thead>
<tr>
<th></th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
<th>SWE</th>
<th>SWIZ</th>
<th>UK</th>
<th>US</th>
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<tbody>
<tr>
<td><strong>OVERALL RANKING</strong></td>
<td>2</td>
<td>9</td>
<td>10</td>
<td>8</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Care Process</td>
<td>2</td>
<td>6</td>
<td>9</td>
<td>8</td>
<td>4</td>
<td>3</td>
<td>10</td>
<td>11</td>
<td>7</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Access</td>
<td>4</td>
<td>10</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>8</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Administrative Efficiency</td>
<td>1</td>
<td>6</td>
<td>11</td>
<td>6</td>
<td>9</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>8</td>
<td>3</td>
<td>10</td>
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<td>Equity</td>
<td>7</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>2</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Health Care Outcomes</td>
<td>1</td>
<td>9</td>
<td>5</td>
<td>8</td>
<td>6</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

Source: Commonwealth Fund analysis.
**Exhibit 3. Health Care System Performance Scores**

Higher performing

UK  AUS  NETH  NZ  NOR  SWIZ  SWE  GER

Eleven-country average

CAN  FRA  US

Lower performing

Note: See How This Study Was Conducted for a description of how the performance scores are calculated.
Source: Commonwealth Fund analysis.
What’s driving the costs of healthcare?
Volume-based (FFS) Payment

• Lack of accountability for the overall quality and costs of care—and for local capacity;

• A flawed payment system that rewards more care, regardless of the value (or quality) of that care.
  • In most settings a licensed physician can order any test, procedure, or treatment regardless of whether there is true patient need
    • Often times these tests or treatments result in unnecessary patient harm!
Physicians who own and bill for nuclear cardiac stress-test technology are twice as likely to order the procedure as those who aren't paid for it, according to a study published in the *Journal of the American Medical Association*. Investigators found that physicians who owned the equipment ordered tests in 10 percent of the cases versus 4.3 percent for those who didn't.

SIDE EFFECTS

Heart Procedure Is Off the Charts in an Ohio City

Dr. Charles D. O'Shaughnessy of North Ohio Heart Center does an angioplasty at EMH Regional Medical Center in Elyria, Ohio, with Susan Croston, a radiology technologist.

By REED ABELSON
Published: August 18, 2006
But in this small, aging industrial city in northeast Ohio, doctors are much more likely than those anywhere else in the country to steer patients toward angioplasty — a treatment that typically involves threading balloon catheters through arteries and sometimes placing drug-coated stents to unblock them.

No one has accused the doctors involved of any wrongdoing. But the statistics are so far off the charts — Medicare patients in Elyria receive angioplasties at a rate nearly four times the national average — that Medicare and at least one commercial insurer are starting to ask questions. And the hospital where most of the procedures take place says it plans to conduct an independent review.
Move to “Value”

Value = Quality (and Service)/Costs

Goal: We want the highest quality of care (and service) at the lowest costs.
Range of Models in Existence or Development

Increasing assumed risk by provider
Increasing coordination/integration required

Current State: Payments for Reporting
Incremental FFS payments for value
Bundled payments for acute episode
Bundled payments for chronic care/disease carve-outs
Accountability for Population Health

From... ..get paid more for doing more

To.... ..profiting by keeping your population of patients healthy, delivering high-quality care, and doing so at less cost
New Payment Models

• Payment bundling
• Accountable Care Organizations
• Shared savings programs
• Clinically integrated networks
• Pay for performance (value-based purchasing)
• Payment penalties for poor performance

All of these models reward higher quality of care and start to reduce the incentive to provide more care (especially unnecessary care).
In BPCI Advanced, all providers bill as they usually would (FFS, DRG, etc). Payment is then adjudicated retrospectively.
“...a substantial part of the variation across HRRs stems from spending on post-acute care, meaning the use of home health services, skilled nursing facilities, rehabilitation facilities, long-term care hospitals, and hospices.”
Semi-annual reconciliation beginning Fall 2019.

CMS Will Get Their Cut No Matter What

Reconciliation or Repayment Calculated Based on Actual Cost Compared to Target Price

Episodic Spending in BPCI Advanced

Episode 1

Negative Reconciliation Amount

Target Price

Positive Reconciliation Amount

Episode 2

Positive Reconciliation Amount
Amount by which all expenditures are less than the Target Price for an Episode

Negative Reconciliation Amount
Amount by which all expenditures exceed the Target Price for an Episode

No More Phased-In Financial Risk
Unlike earlier bundles, participants will take on total financial risk from the outset of the program
Accountable Care Organizations

• Groups of providers across different settings—primary care, specialty physicians, hospitals, clinics, and others—who chose to come together to jointly share responsibility for overall quality, cost, and care for a large patient population.
  • These providers recognize that poorly coordinated care from these entities can lead to increased costs from things like redundant tests and overlapping care.
Patient-centered Medical Home (including programs such as CPC+)

• Usually includes some set monthly payments on top of existing funding models, to fund a highly coordinated team of primary care professionals, which may include, depending on the patient’s needs, physicians, nurse practitioners, medical assistants, nutritionists, psychologists, and social work.
  • Allow professionals to practice at the top of their license
  • Patient care delivered by a team – physician or APP care may not be needed
Direct Patient Contracting

• The patient contracts directly with a physician, clinician, or practice to pay directly out-of-pocket for some or all medical services that are provided by the clinician or practice. Direct patient contracting models include a number of different arrangements including direct primary care and concierge care.
Managed Care

• Intended to reduce unnecessary health care costs through economic incentives for physicians and patients to select less costly forms of care; programs for reviewing the medical necessity of specific services; increased beneficiary cost sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with health care providers; and the intensive management of high-cost health care cases.
Reference Pricing

• The price that a purchaser announces that it is willing to pay for a good or service.

• Often involves active intervention with the insured patient to direct them to the lowest cost service/provider
Issues that Continue to Drive the National Discussion
Figure 8.
Uninsured Rate by State: 2018
(Civilian noninstitutionalized population)

A state with a circle around its abbreviation expanded Medicaid eligibility on or before January 1, 2018.

Note: For information on confidentiality protection, sampling error, nonsampling error, and definitions in the American Community Survey, see <https://www2.census.gov/programs-surveys/acs/tech_docs/accuracy/ACS_Accuracy_of_Data_2018.pdf>.

2017 Uninsured Rate for Working-Age Adults Aged 18 to 64, Living at or Below 138 Percent of Poverty

The data provided are indirect estimates produced by statistical model-based methods using sample survey, decennial census, and administrative data sources. The estimates contain error stemming from model error, sampling error, and nonsampling error.

Source: U.S. Census Bureau, 2017 Small Area Health Insurance Estimates (SAHIE) Program.
<table>
<thead>
<tr>
<th>Reason</th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undocumented immigrant</td>
<td>5.4</td>
</tr>
<tr>
<td>ACA tax credit eligible</td>
<td>5.3</td>
</tr>
<tr>
<td>Declined employer offer</td>
<td>4.5</td>
</tr>
<tr>
<td>Medicaid eligible adult</td>
<td>3.8</td>
</tr>
<tr>
<td>Income above subsidy ceiling</td>
<td>3.0</td>
</tr>
<tr>
<td>Medicaid eligible child</td>
<td>2.6</td>
</tr>
<tr>
<td>Coverage gap*</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Total: 27.2m

Source data: Kaiser Family Foundation
Persons under Age 65
Surprise Medical Bills

Heart Attack Patients May be More at Risk for Surprise Medical Bills

- The share of emergency visits with at least one out-of-network charge:
  - Heart Attacks: 27%
  - All episodes: 18%

- The share of in-network inpatient stays with at least one out-of-network charge:
  - Heart Attacks: 23%
  - All episodes: 16%
Figure 1.10
Average Annual Premiums for Single and Family Coverage, 1999-2019

* Estimate is statistically different from estimate for the previous year shown (p < .05).

Figure 1.1
Average Annual Premiums for Covered Workers, Single and Family Coverage, by Plan Type, 2019

* Estimate is statistically different from All Plans estimate (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2019
Deductible spending has risen while copayment spending has fallen

Cumulative increases in health costs, amounts paid by insurance, amounts paid for cost sharing and workers wages, 2004-2014

- More out-of-pocket spending for healthcare
- Widening gap between wages and out-of-pocket costs!

http://www.healthsystemtracker.org/brief/payments-for-cost-sharing-increasing-rapidly-over-time/#item-start
Out-of-pocket costs continue to grow faster than workers’ wages.

Cumulative growth in out-of-pocket and total health spending for people with large employer coverage, 2007-2017

Source: KFF analysis of IBM MarketScan Commercial Claims and Encounters, 2003–2017. • Get the data
• PNG
Figure A
Average Annual Worker and Employer Premium Contributions and Total Premiums for Family Coverage, 2009, 2014, and 2019


Figure A: Average Annual Worker and Employer Premium Contributions and Total Premiums for Family Coverage, 2009, 2014, and 2019
66% of those in employer health plans with high deductibles say they couldn't pay a medical bill the size of their deductible without going into debt. (KFF/LATimes Poll)
Cost Shifting

• Cost shifting occurs when a hospital or other health-care provider charges an insured patient more than it does an uninsured patient for the same procedure or service. Those with health insurance, in effect, pay for the financial loss hospitals incur when they provide services to those without insurance.

“.......the practice by a hospital of charging more to one group of patients because another group is not paying its share.”

Hospitals performed small amount of cost-shifting, study finds

Figure 1


132% of their actual costs of care
The Huge Waste in the U.S. Health System

A study finds evidence for how to reduce some of it, but also a large blind spot on how to remove the rest.

“…. roughly 20 percent to 25 percent of American health care spending is wasteful.”

Figure. Proposed “Wedges” Model for US Health Care, With Theoretical Spending Reduction Targets for 6 Categories of Waste

“Business as usual” national health care expenditures

- Failures of care delivery
- Failures of care coordination
- Overtreatment
- Administrative complexity
- Pricing failures
- Fraud and abuse

Growth in national health care expenditures matches GDP growth

US National Health Care Expenditures, % of GDP

Year


17.5 18.0 18.5 19.0 19.5 20.0 20.5
Jesus and Olivia

- The discounted excess lifetime medical spending for people with diabetes is $124,600 ($211,400 if not discounted) despite a reduced life expectancy.

- The lifetime cost per person of first strokes occurring in 1990 is estimated to be $103,576 averaged across all stroke subtypes.
“The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in shadows of life, the sick, the needy, and the handicapped.”

Hubert H. Humphrey