# HELP Act Oversight Committee
# 11-22-16

## Cost Remains American Healthcare #1 Issue

American healthcare was broken before the Affordable Care Act with two glaring issues being access (15.7% uninsured nationally) and cost.

Six years post ACA the national uninsured rate is down to 8.6% but cost remains a huge problem (and there are other problems too). American healthcare remains broken.

The common problem of 2010 and 2016 is the cost of American healthcare. Further, affordability of healthcare for all except those covered on the governmental programs (primarily Medicare and Medicaid) is much worse now than in 2010 – primarily due to the huge increases since 2010 in deductibles and co-payments for those with employer provided health insurance. According to a recent study by the Kaiser Family Foundation, deductibles for employer provided insurance have risen more than six times faster than workers' earnings since 2010. Therefore, healthcare costs are now actually a bigger problem than they were in 2009 prior to the passage of the Affordable Care Act (ObamaCare) in 2010.

Hopefully, the November elections result in real progress on addressing American healthcare cost issues vs. all the empty rhetoric and politics leading up to the elections.

Healthcare Coverage In The United States

Now let's turn to Americans covered by the different programs of coverage (per statistics from the Kaiser Family Foundation):

| | |
|---|---|
| • Employer provided health insurance | 48% |
| • Individual policies | 3% |
| • Policies purchased on the health insurance exchanges | 4% |
| • Medicaid | 20% |
| • Medicare | 14% |
| • Other governmental | 2% |
| • Uninsured | 9% |
| | 100% |

For comparison, the percentages at Benefis Health System (our payment sources) vary rather dramatically from the above national numbers with governmental being our primary payment source at Benefis Health System:

| | |
|---|---|
| • Governmental (Medicare, Medicaid, Tri-Care/Champus, IHS) | 72.4% |
| • Uninsured | 3.7% |
| • Commercial (employer provided, individual and exchange) | 23.9% |
| | 100 % |

## Who Do Healthcare Prices Effect Most and How Are They Set

What hospitals and other healthcare providers charge is less material to Medicare and other governmental healthcare programs due to the fact that Medicare sets maximums for what they will pay for each service/procedure, known as allowable charges. So, using the national numbers I quoted previously, 36% of the payers (governmental payers) nationally decide on price – not the hospital or other healthcare provider. I'm oversimplifying a bit but that is basically how it works.

Second, almost all hospitals in the country lose money on governmental payers (Medicare, Medicaid, Tri-Care/Campus, IHS). To make up for what they lose on the governmental payers and those without insurance who cannot pay, they charge much higher prices to those with commercial (largely employer provided) insurance. This is known as cost shifting and has been going on for a long time in American healthcare. It is basically a hidden (but certainly not secret) tax in the form of higher prices to those with commercial insurance.

How much of a hidden tax the commercial insurance company (and those they cover) pays depends on the negotiating skill and market position of the insurance company and other factors. However, the charge paid by a commercial insurance company/someone with commercial insurance can be 200% or more than what Medicare pays. Factors which could dramatically reduce cost shifting would include a fully insured population and a reasonable payment rate from all governmental payers.

Healthcare providers nationally have an ever shrinking pool of who they can cost shift to. The reasons are that employer provided insurance is gradually but surely shrinking. In 1999 71% had employer provided health insurance. Today that percentage is 48%.

So "price" is much more material to those with commercial (employer provided or self-purchased) insurance and those who pay their own costs than to those on governmental programs. Further, these folks with commercial insurance or self-pay are who most need price transparency (and who could benefit most from comparison shopping).

Price transparency will be one (of a number) of healthcare topics which will be addressed/debated in the upcoming Montana Legislative Session.

## Few Related Points Specific To Benefis Health System

- 72.4% of our patients are covered by governmental programs (48% Medicare). That is why it was critical for us to start our cost reduction journey in 2009 – which led to us achieving Medicare breakeven in 2012 (and maintaining it since).
- In 2014 we had an outside group conduct a study of all of our prices to assure that our prices meet the tests of common sense and rationality.
- Only 24% of our patients have non-governmental coverage.
- Benefis Health System supports price transparency.

**Medicare's Additional Plans To Cut Its Cost**

As previously explained, traditional governmental coverage plans make up 72.4 percent of Benefis Health System's payers (with Medicare alone representing 48% of BHS' patients) and those plans basically set their own pricing.

While they basically set their own pricing, they, and let's talk Medicare specifically, are vulnerable from a cost perspective to the volume of service(s) provided to a Medicare patient. The more services provided a Medicare patient, the more it costs Medicare. This has been referred to as payment for volume.

To reduce this cost factor Medicare is gradually moving away from payment for volume to payment for outcomes, with the speed of that shift dependent on the market. To date, with the exception of voluntary pilot programs (Medicare ACOs, bundled payment pilots, Pioneer ACOs, and the Comprehensive Primary Care initial pilot) the shift has been gradual.

Mandatory programs (for all Medicare providers) to date have included:

- The hospital readmissions reductions program – hospitals are penalized up to 3% for avoidable 30 day readmissions for six conditions.

- The hospital value-based purchasing program – hospitals are rewarded for efficiency, safety, satisfactions and outcomes against historic costs. 2% of payments at risk by 2017 (see Attachment #1 for an article on this program).

- The hospital-acquired condition program – hospitals in the bottom quartile are penalized up to 1% for hospital-acquired infections.

The downside risk (and upside potential) for hospitals in the above mandatory, all markets programs has been limited.

However, Medicare plans to speed the transformation from payment for volume to payment for outcomes and not just for hospitals but for physicians as well. Two examples:

- **MACRA** (which few hospitals and fewer physicians truly understand) goes into effect on 1-1-17. MACRA increases downside risk significantly. The Advisory Board Company predicts that MACRA will drive many more physicians who are currently independent to become employed by Hospitals/Health Systems.

- In 98 markets across the country **bundled payments** are mandatory, first for joint replacements and then for cardiac conditions. These bundled payments are for all Part A and Part B Medicare payments for 90 days post discharge. There is no doubt that Medicare will expand the bundled payment concept to the entire country and for more and more procedures. While Benefis Health System is not in one of those initial 98 markets, we are well positioned for bundled payments due to our cost structure and our comprehensive continuum of care.

**So What Approaches Are Non-Governmental Payers Taking**

As mentioned on the first page of this report, increasing deductibles and co-payments (for commercial insurance offered by employers as well as for the commercial plans offered on the exchange) has been on the rise.

Another approach is referenced based pricing whereby a commercial payer pays a percentage (usually a percentage well above 100%) of what Medicare would pay for the same procedure or services.

Another approach is narrowing networks (keeping lower cost providers in an insurance plan's network and making higher cost providers out of network).

And, as bundled payments become the norm in the Medicare program, more and more commercial insurance companies will pursue that same payment strategy.

John H. Goodnow, Chair
CEO Benefis Health System

# Medicare feels heat to pull plug on value-based purchasing

By Elizabeth Whitman

The latest results of Medicare's Hospital Value-Based Purchasing program were dismal but unsurprising. The program's use of financial sticks and carrots to motivate 3,000 U.S. hospitals to provide better care resulted in more hospitals getting dinged for poor performance in 2017, not fewer.

Now some policy experts are beginning to wonder if the program should be shelved.

Weigh all the evidence on the Hospital Value-Based Purchasing program, and "you almost wonder, is it time to retire it?" said Francois de Brantes, executive director of the Health Care Incentives Improvement Institute.

"We actually have a good amount of evidence on this. We know that the value-based purchasing program has had very little, if any, effect," said Dr. Ashish Jha, a professor of health policy at the Harvard School of Public Health.

A study that Jha and other researchers published in BMJ in May found scant evidence that the program reduced mortality rates at participating hospitals.

In fiscal 2017, roughly 1,600 hospitals—200 fewer than in 2016—will receive performance-based bonuses, and about 1,300 hospitals will be penalized, according to data posted Nov. 1.

The program, which took effect in October 2012, is one of several established by the Affordable Care Act to tie Medicare fee-for-service payments to the quality and efficiency of care provided. Its effectiveness is diminished by a variety of factors—chief among them its limited financial consequences and the fact that hospitals have bigger fish to fry.

The CMS creates a pool of money for the bonuses by docking 2% from all hospitals' base DRG payments. Then, the agency redistributes the money according to each hospital's performance compared with the rest of the hospitals in the program and against its own performance over time.

For roughly half the hospitals involved, base DRG payments will ultimately change by no more than half a percentage point in 2017. The rewards or penalties in those cases amount to tens or hundreds of thousands of dollars—chump change for a hospital with revenue in the hundreds of millions.

The financial swing "isn't that material," said Dr. William Conway, executive vice president of Henry Ford Health System in Detroit. Rather, the five-hospital system pays attention to the components of the program "because in aggregate they represent good care."

**At the Cleveland Clinic**, Chief Quality Officer Dr. Cindy Deyling likewise said adhering to the program is "more about doing the right thing for patients, rather than the 2% reimbursement that is at risk." It has contributed to improvements in the quality of care, she said, but it's "one of several components of our overall value strategy."

In a healthcare landscape dominated by payment reform efforts, other value-based payment initiatives that carry greater financial risk are competing for—and winning—hospitals' attention and resources.

The Hospital Value-Based Purchasing program helps guide clinical efforts across Catholic Health Initiatives "by defining the metrics and desired results at each of our locations," said Dr. Christopher Stanley, vice president for population health for the Englewood, Colo.-based system, which operates 103 hospitals spanning 19 states.

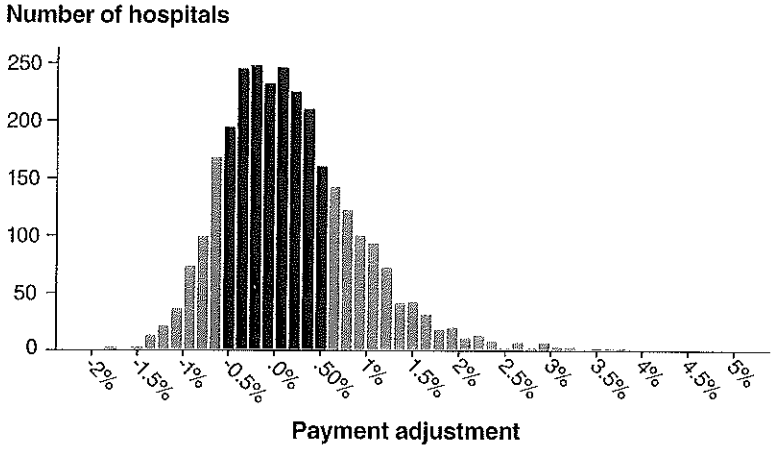
But CHI, which had $15.2 billion in operating revenue in fiscal 2015, also participates in Medicare's voluntary Bundled Payments for Care Improvement initiative, which carries both financial rewards and penalties. CHI opted for bundled payments for nearly three dozen different types of episodes of care.

"Generally speaking, CHI's incremental investment and focus on CMS' episode-of-care programs has been larger than our work in the VBP program," Stanley said.

If the program barely has an impact, then why keep it? "I think it allows us to feel like we're doing something on trying to improve patient outcomes," said Jha, who favors revising it by condensing its measures to those that matter to patients. "We want to be able to say we're paying for quality." ●

## VBP's modest financial incentive

Payments will go up or down less than 0.5% in 2017 for more than half the hospitals in the program




*Source: HHS; data analysis by Art Golab*