

Health Policy 101

Humayun J. Chaudhry, D.O., M.S., S.M., FACP, FACOI

Chairman, Department of Medicine and

Assistant Dean for Health Policy

N.Y. College of Osteopathic Medicine/NYIT

hchaudhr@nyit.edu

August 19, 2005

Session Outline

- Introduction to Health Policy 101
- Healthcare and Medical Education in the United States, 1700s-now
- Introduction to Health Economics
- Medicare, Medicaid and Managed Care
- Healthcare Spending Trends, 1960-now
- Latest Physician Workforce Studies
- Conclusion, Review, Q/A

Health Care ("The Good Ol' Days")

- The Patient visits a Doctor when ill or for the follow-up care of an illness
- The Doctor provides health care (commodity)
- The Doctor charges a fee
- The Patient pays the full fee directly to the Doctor at the time of service
- This is the "Bilateral Model"

“Modern” Health System

- Prevalent in many parts of the world
- The Consumer visits a Provider for a check-up, an illness, or a follow-up
- The Provider provides health care
- The Provider bills a third party primarily and perhaps also the Consumer (co-payment)
- The Payor and Consumer end up paying the Provider some (but not all) of the full fee
- This is the “Trilateral Model”

Fee-For-Service (FFS)

- A method of payment that provides reimbursement, usually in pre-determined amounts, upon the occasion of the provision of a specific service
- *Consumer Response*
 - Follows a demand curve
 - FFS price goes up, utilization goes down
 - FFS price goes down, utilization goes up
- *Provider Response*
 - Goal is profit maximization
 - Output tends to be raised

The Civil War: Birth of Government Regulation

- 160,000 soldiers died from wounds
- 375,000 soldiers died from disease
 - Dysentery, malaria, measles, typhoid fever, small pox, tuberculosis, pneumonia, bronchitis, scarlet fever, and scurvy
 - Physicians stood virtually helpless
 - Only effective drugs: chloroform, ether, quinine
- U.S. imposed compulsory medical examinations for military physicians
 - Pass Rate: 25%

Flexner Report, 1910

- The “most important event in the history of American and Canadian medical education”
- A commentary on the condition in the early 1900s, gave rise to modern medical education
- Named after Abraham Flexner (1866-1959), a secondary school teacher and principal who prepared it
- Triggered much-needed reforms in the standards, organization and curriculum of North American medical schools

The Problem

- National health expenditures have grown
 - 1960: \$27 billion
 - 1990: \$666 billion
 - 2003: \$1.7 trillion (GDP share: 15.3%)
 - 2014 (projected): \$3.6 trillion (projected GDP share: 18.7%)

Health Economics

- Nobel Laureate Kenneth Arrow (1963) helped establish Health Economics as a field. He stressed...
 - Prevalence of uncertainty in health care
 - Supply and demand are irregular
 - Since markets for insurance would often fail to arise in this model, a role for government exists



Medicare

- A federal entitlement plan created in 1965 that provides medical benefits to the aged (people over 65) and people who have received Social Security disability payments for more than two years, and people with end-stage renal disease
- Initially, reimbursement was based on a CPR (customary, prevailing, reasonable) formula
- Program is run by the CMS (Centers for Medicare and Medicaid Services), previously HCFA
- Since 1996, CMS has been responsible for implementing 700 provisions of five major laws related to health care costs, insurance, benefits and overall accountability

Medicare

- Medicare covers 40 million Americans, a number expected to balloon to 80 million by the year 2030
- Medicare has two parts:
 - Hospital insurance, or **Medicare Part A**, which helps pay for care in a hospital and skilled nursing facility, home health care and hospice care. Most people do not have to pay for Medicare Part A
 - Medical insurance, or **Medicare Part B**, which helps pay for doctors, outpatient hospital care and other medical services. Most people pay for Medicare Part B

Medicaid

- A means-tested federal program created in 1965, administered and operated by individual states, that provides medical benefits to eligible low-income persons.
- The costs of the program are shared by the federal government, states, and, in New York, counties
- In 2003, Medicaid covered 54 million low-income people at a cost of \$276 billion

What's wrong with paying
doctors and hospitals for treating
Medicare and Medicaid patients
with CPR rates?

Diagnosis-Related Groups

- A diagnosis-based prospective payment classification system started in 1983 that is used by Medicare and Medicaid to reimburse hospitals for inpatient costs on a “per discharge” basis, regardless of the patient’s length of stay or actual cost of hospitalization
- There are more than 480 DRGs
- Originally, reimbursement rates had national, regional, and hospital-specific components
- In 1989 Medicare went to national rates, but rates vary by urban/rural locations, #residents per bed for teaching hospitals, #low income pts treated

Balanced Budget Act of 1997

- Reduced Medicare payments to virtually every clinical laboratory, hospital, skilled nursing facility and home health care agency (estimated reduction of \$112 billion for the period 1998-2002)
- Subsequent legislation reversed a small proportion of those cuts but not before some hospitals closed, merged or downsized

Managed Care

- The process of applying business methods to the routine practice of medicine
- Kaiser Permanente, founded because Henry Kaiser wanted to make cement and build dams in remote places that lacked medical care for his workers, began as an anomaly 75 years ago

Managed Care

- Proportion of Population Enrolled in Managed Care : 1990 (13.5%), 2000 (30%)
- Definition: A system of health care delivery that attempts to influence or control utilization of health care services and the costs associated with such services
- Under managed care, organizations that foot the bill for a patient's care decide how much care a patient receives, of what kind, and by which providers. They also decide how much money providers will receive and how that money is paid

Capitated Payment System

- “Entity responsible for patient care” (Provider) receives a fixed periodic sum (adjusted for age, sex, etc.) for each patient that covers the costs of utilization by the patient. (PMPM payments)
- *Consumer Response*
 - Small co-payment, so price of care is low
 - Utilization tends to increase
- *Provider Response*
 - Incentive to decrease utilization of services and decrease consumer visits
 - Output tends to become lower

Preferred Provider Organization (PPO)

- An arrangement whereby a group of Providers agrees to provide services to a defined group of patients at an agreed-upon rate for each service
- *Consumer Response*
 - Though supply of Providers is limited and (often) co-payments are low, see high demand
- *Provider Response*
 - Though price restricted, output will be raised until there is equilibrium between supply and demand

Point-of-Service (POS) Plans

- Allows consumers to use Providers not on a Managed Care company's rolls.
- *Consumer Response*
 - Since high deductible and/or high co-payment, demand likely to be lower
- *Provider Response*
 - Payments by Plans sufficiently high, so an incentive exists to raise output

The Profession of Medicine: What Makes Us Unique?

- We put our patients first
 - As physicians, we place our patients' health needs and well-being before any other end
 - We act as our patients' advocates
 - We accept, promote, and honor a fiduciary trust on behalf of our patients

The Profession of Medicine

- We maintain a special body of knowledge
 - As physicians, we maintain, apply and transmit a special body of knowledge not generally available outside of the profession
 - We advance the science of medicine: physician scientists generate new medical knowledge as they practice medicine

The Profession of Medicine

- We reserve to ourselves the right to evaluate our own quality
 - Given the body of special knowledge that defines the medical profession, only physicians are qualified to assess medical quality. We honor that obligation: we hold one another accountable for our behavior and for the outcomes we achieve on behalf of our patients

Variation in Clinical Practice

- Variation in hospitalization rates
- High rates of care judged inappropriate or equivocal
- Variation in the process of care
- Variation in “expert” opinion

Known Defects

- Overuse and inappropriate care
- Underuse of effective care
- Variation in care patterns
- Errors in medical care
- Service flaws
- Waste

Types of Improvement

- Reducing defects from the viewpoint of the patient
- Reducing cost, while maintaining or improving quality
- Providing a new product or service, or an old one at an unprecedented level

Top 5 Concerns of Physicians about Managed Care

- Prompt payment: 82%
- Administrative hassles: 62%
- Downcoding: 62%
- Lack of bargaining power: 62%
- All other reimbursement issues: 38%

- Source: AMA Dept of Private Sector Advocacy

Managed Care

- A 1999 survey revealed that negative view of managed care are widespread among medical students, residents, faculty members and medical school deans
- Several medical schools, including NYCOM, have instituted elective clerkships at managed care settings for their students to better understand how care can be delivered efficiently and comprehensively within such systems

US Health Care Spending Growth

- From 1970-1993, average annual growth for health care spending was 11.5%
- From 1993-1999, growth rate diminished to 5% annually. Why?
 - Impact of managed care
 - Low general/medical inflation
 - Excess capacity among providers
 - Growth in GDP
- By 2000-2001, health care spending growth picked up again, increasing 7.2% and 8.9%, respectively (In 2003, it peaked at 9.3%)

US Health Care Spending Growth

- In 2004, health care spending growth declined to 7.8%
- Why?
 - States' decision to limit Medicaid funding
 - Modest deceleration in medical prices and use (decreased medical inflation)
 - Decreased prescription drug spending growth

Physician Workforce Issues

- Is there a “**Shortage of Physicians** or a **Surplus of Assumptions?**” – Salsberg/Forte, *Health Affairs*, 2002
- Throughout the past two decades, public and private health care organizations have debated the adequacy of the physician workforce in the United States
- Depending on the source of information and political environment, conventional wisdom vacillates between predictions of an **oversupply** and predictions of a substantial **shortage** across all medical specialties

Why is Physician Workforce Difficult to Predict?

- Length of Training (7-10 years)
- Fierce Competition for Physicians in Certain Locales
- Explosion of New Knowledge
- Changing Demographics
- Changing Practice Patterns
- Changing Attitudes towards Workload

Physician Workforce, 1950s-1970s

- From 1950s to early 1970s, concerns about physician shortages prompted measures by federal and state governments to increase physician supply:
 - Providing funds to **construct new medical schools**
 - Providing funds to **increase medical school class sizes**
 - Offering **loans and scholarships** to medical students
 - **Paying hospitals through Medicare** to subsidize residency training costs (GME)

Osteopathic Workforce Study 2004

■ Conclusions

- The osteopathic profession is **rapidly growing** (48,678 practicing osteopathic physicians in 2003 with 2,800+ new DOs a year)
- The **gender make-up** of the profession will change
- The growth of the profession by numbers is **unplanned and opportunistic** and does not necessarily occur based on the needs of the profession

AAMC 2005 Report

- “In the 1980s and 1990s... the AAMC and other national organizations recommended steps to reduce physician supply in order to obviate (a) predicted surplus of physicians by the beginning of the 21st Century.
- “It now appears those predictions were in error. The year 2000 has come and gone, and there is no convincing evidence that the current supply of physicians exceeds the demand for physicians’ services.”

AAMC 2005 Report

■ Recommendations

- Entry level positions in U.S. medical schools should be increased by 15% from the 2002 level over the next decade
- Aggregate number of GME positions should be expanded to accommodate the increased number of graduates (translation: eliminate the cap on existing residency positions)

Suggested Readings

- Heffler S, Smith S, Keehan S et al. Trends: U.S. Health Spending Projections for 2004-2014. *Health Affairs*. February 23, 2005. www.healthaffairs.org
- Fuchs, VR. What's Ahead for Health Insurance in the United States? *N Engl J Med*. 346(23): 1822-1824. June 6, 2002.
- Doherty, RB. What History can Teach us about Medical Politics Today. *ACP-ASIM Observer*. Page 10. July/August, 2002.
- Krugman, P. Bad Medicine. Op-Ed. *NY Times*. Page A23. March 19, 2002.
- Stolberg, SG. Bush Urges a Cap on Medical Liability. *NY Times*. July 26, 2002.
- Pear, R. Medicare Drugs for Those in Need Sway Democrats in Senate. *NY Times*. July 26, 2002.
- Inglehart, JK. Medicare's Declining Payments to Physicians. *N Engl J Med*. 346(24):1924-1930. June 13, 2002.

Suggested Readings

- Fuchs VR. Who Shall Live? *Health, Economics and Social Choice*. Basic Books, 1983; Introduction, Ch. 1.
- Epstein AM, Blumenthal D. Physician Payment Reform: Past and Future. *The Milbank Quarterly* 1993; 71(2):193-215.
- Waid MO. Overview of the Medicare and Medicaid Programs. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*, 1998. Pages 1-11.
- Reinhardt UE. Wanted: a Clearly Articulated Social Ethic for American Health Care. *JAMA*. 1997;278:1446-7.
- Vladeck, BC. Learn Nothing, Forget Nothing – the Medicare Commission Redux. *N Engl J Med*, 345(6): pp. 456-458. August 9, 2001