An Update on Health Care Reform and Comparative Effectiveness Research

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• An Update on Health Care Reform
  – Where are we?

• Comparative Effectiveness Research (CER)
  – SCOAP-CERTN as the perfect platform
### Implementation Timeline - Affordable Care Act (ACA)

<table>
<thead>
<tr>
<th><strong>Increasing Coverage and Access to Affordable Care</strong></th>
<th><strong>Consumer Protections</strong></th>
<th><strong>Improving Quality/ Lowering Costs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NOW: 2010</strong></td>
<td><strong>NOW: 2010</strong></td>
<td><strong>NOW: 2010</strong></td>
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<tr>
<td>Pre-existing Condition Insurance Plans (PCIPs) offers coverage to uninsured.</td>
<td>No pre-existing condition exclusions for children under age 19</td>
<td>Eliminates co-pays and deductibles for preventive services (commercial plans and Medicare)</td>
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<tr>
<td>Extends dependent coverage to young adults up to age 26</td>
<td>Insurance companies cannot drop coverage mid-stream (no rescissions)</td>
<td>Cracks down on health care fraud</td>
</tr>
<tr>
<td>Small business tax credit: up to 35% if offer insurance</td>
<td>Eliminates lifetime $ limits on coverage</td>
<td>Closing Medicare Donut Hole: $250 rebate on medicines</td>
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<tr>
<td>Expands primary care workforce via Public Health and Prevention Fund</td>
<td>New independent appeals process, with grants to states for offices of health insurance consumer assistance</td>
<td>Early retirees: $5 billion federal fund to subsidize high cost medical claims</td>
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<tr>
<td>New resources help consumers take control of their health care: HealthCare.gov ~ CuidadodeSalud.gov</td>
<td></td>
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<tr>
<td><strong>2011</strong></td>
<td><strong>2011</strong></td>
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<tr>
<td>Increases access to long term care services at home and in the community</td>
<td>Streamlines paperwork and administrative costs</td>
<td>Closing Medicare Donut Hole: 50% discount on brand name prescription drugs</td>
</tr>
<tr>
<td>Primary care: New investments to increase the no. of primary care doctors, nurses, nurse practitioners, physician assistants</td>
<td>Requires Medical Loss Ratio (MLR): insurance plans must pay 80-85% of revenues on subscribers’ health care.</td>
<td>States can require insurance co.s to submit justification for requested premium increases. Adds transparency, strengthens State oversight of premiums</td>
</tr>
<tr>
<td>Expands community health centers</td>
<td>Connects Medicare payments to quality outcomes</td>
<td>Establishes “Independent Payment Advisory Board” for Medicare</td>
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<td><strong>2012</strong></td>
<td><strong>2012</strong></td>
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<tr>
<td>Establishes CLASS program, a voluntary option for long-term care insurance</td>
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<td><strong>2013</strong></td>
<td><strong>2013</strong></td>
<td><strong>2013</strong></td>
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<tr>
<td>Increases Medicaid payments for primary care services.</td>
<td>Limits the tax deductibility of compensation to health insurance company executives</td>
<td>Expands Medicare authority to bundle payments</td>
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<tr>
<td>Additional funding for the Children’s Health Insurance Program (CHIP)</td>
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<tr>
<td><strong>2014</strong></td>
<td><strong>2014</strong></td>
<td><strong>2014</strong></td>
</tr>
<tr>
<td>Insurance Exchanges available individuals, small businesses. Small business tax credit expansion</td>
<td>Eliminates discrimination due to pre-existing condition or gender</td>
<td>Medicare delivery system changes and cost containment policies implemented</td>
</tr>
<tr>
<td>Medicaid expands to everyone at or below 133% of the poverty level</td>
<td>Eliminates annual $ limits on coverage</td>
<td>[Medicare Donut Hole eliminated: 2020]</td>
</tr>
</tbody>
</table>
Exhibit 4. Uninsured Rate Among Adults Ages 19–64, 2008–09 and 2019

Views on Health Reform Remain Divided

As you may know, a new health reform bill was signed into law earlier this year. Given what you know about the new health reform law, do you have a generally favorable or generally unfavorable opinion of it?

Source: Kaiser Family Foundation *Health Tracking Polls*
The Individual Mandate

Section 1501(b) [IRC Sec. 5000A]

Each individual must maintain medical insurance coverage, including for dependents, for each month (starting in 2014)

• Does not apply to non-citizens or unlawful aliens
• Does not apply to incarcerated individuals
• In effect, does not apply if premium exceeds 8% of income
• In effect, does not apply to individuals with income under 100% of poverty
The Individual Mandate

Section 1501(b) [IRC Sec. 5000A]

Monetary penalty imposed for failure to retain required coverage (with various caps)

- **Overall cap**: Cost of a qualifying plan on an exchange

- **Otherwise**: Capped at about $2100 or 2.5% of income (whichever is greater)

[Section 1002(a) Reconciliation Bill]
The Individual Mandate

Why the individual mandate?

• Adverse Selection problem
• Unsustainable system without revenue stream from uninsured
• Others?
The Health Exchanges Section 1311(b)

• “Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange” [“Exchange”] [Section 1311(b)(1)]
• “An Exchange shall be a governmental agency or nonprofit entity that is established by a State” [Section 1311(d)(1)]
• No federal funds for continued operation of Exchanges after December 31, 2015 [Section 1311(d)(5)]
• If a state chooses not to “elect” to set up an Exchange, then the federal government “shall... establish and operate” an Exchange within that state [Section 1321(c)]
The Expanded Medicaid Mandate

• Requires states to cover under Medicaid persons with incomes under 133% of poverty [Section 2001(a)(1)(C)]

• Federal matching for newly eligible Medicaid beneficiaries [Section 1201 Reconciliation Bill]
  – 2014 – 2016: 100%
  – 2017: 95%
  – 2018: 94%
  – 2019: 93%
  – 2020 (and thereafter): 90%
Legality of the Individual Mandate

• 27 State AG’s have charged that the individual mandate is unconstitutional.

• 4 court decisions
  – 2 in favor
  – 2 against
Where are we now?

• IN FAVOR

• [t]he ‘fundamental need for health care and the necessity of paying for such services received’ creates the market in health care services, of which nearly everyone is a participant . . . . Far from ‘inactivity,’ by choosing to forgo insurance, Plaintiffs are making an economic decision to try to pay for health care services later, out of pocket, rather than now, through the purchase of insurance.

• Collectively shifting billions of dollars, $43 billion in 2008, onto other market participants . . . . How participants in the health care services market pay for such services has a documented impact on interstate commerce.
Where are we now?

• Opposed
  - Florida v. United States Department of Health and Human Services (N.D. Fla., Jan. 31, 2011), Judge Roger Vinson ruled unconstitutional not only the individual mandate, but also the entire law. He reasoned that the law could not function as Congress intended if the individual mandate, and the funding it would provide, were severed from it.
The President, OMB, and HHS

• “Better information about the costs and benefits of different treatment options…could eventually lower health care spending…”
  – Peter Orszag, CBO, Testimony from Congressional Hearing on 6/12/07

• "I think there's a general recognition that the system we have in America is fundamentally broken. We spend more than any country on Earth. Our health results look like we're a developing nation."
  – Secretary Kathleen Sebelius, HHS, CNN’s “State of the Union,” 8/16/09
CBO estimates that the information produced by enacting section 904 would reduce total spending for health care services. Specifically, total spending—by public and private purchasers—would be reduced by about $0.5 billion over the 2008-2012 period and by about $6 billion over the 2008-2017 period. Direct spending by the federal government—mostly for Medicare, Medicaid, and the Federal Employees Health Benefits program—would be reduced by $0.1 billion over the 2008-2012 period and $1.3 billion over the 2008-2017 period. (Those amounts would constitute a very small fraction of overall federal outlays for those programs.) Thus, enacting section 904 would increase federal direct spending by $0.5 billion over five years and $1.1 billion over 10 years, CBO estimates.

That estimate assumes that better information about which health care services and procedures are ineffective or less effective than alternative services would lead to federal savings primarily through changes in physicians’ practice patterns. To a lesser extent, some savings might also occur through changes in coverage rules that can be implemented under current law, although CBO did not make explicit assumptions about what those changes would be.
Demographics = unsustainable spending growth rates

CBO Projections for Social Security, Medicare, and Medicaid

Source: Congressional Budget Office, “The Long-Term Budget Outlook, December 2003
Assumptions: Excess cost growth of 2.5% for both Medicare and Medicaid; Social Security benefits paid as scheduled under current law
Projected growth rates as a percentage of GDP

## Estimated Contributions of Selected Factors to Long-Term Growth in Real Health Care Spending per Capita, 1940 to 2000

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Aging of the Population</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Changes in Third-Party Payment</td>
<td>10</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Personal Income Growth</td>
<td>11-18</td>
<td>5</td>
<td>&lt;23</td>
</tr>
<tr>
<td>Prices in the Health Care Sector</td>
<td>11-22</td>
<td>19</td>
<td>Not Estimated</td>
</tr>
<tr>
<td>Administrative Costs</td>
<td>3-10</td>
<td>13</td>
<td>Not Estimated</td>
</tr>
<tr>
<td>Defensive Medicine and Supplier-Induced Demand</td>
<td>0</td>
<td>Not Estimated</td>
<td>0</td>
</tr>
<tr>
<td>Technology-Related Changes in Medical Practice</td>
<td>38-62</td>
<td>49</td>
<td>&gt;65</td>
</tr>
</tbody>
</table>
Sources of Growth in Projected Federal Spending on Medicare and Medicaid

<table>
<thead>
<tr>
<th>Year</th>
<th>Effect of Excess Cost Growth</th>
<th>Effect of Aging of Population</th>
<th>Interaction of Aging and Excess Cost Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>20</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>2012</td>
<td>15</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>2017</td>
<td>10</td>
<td>5</td>
<td>5</td>
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<tr>
<td>2022</td>
<td>5</td>
<td>5</td>
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<tr>
<td>2027</td>
<td>10</td>
<td>5</td>
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<tr>
<td>2032</td>
<td>15</td>
<td>5</td>
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<td>2037</td>
<td>20</td>
<td>5</td>
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<td>2042</td>
<td>25</td>
<td>5</td>
<td>5</td>
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<td>2047</td>
<td>30</td>
<td>5</td>
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<td>2052</td>
<td>35</td>
<td>5</td>
<td>5</td>
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<tr>
<td>2057</td>
<td>40</td>
<td>5</td>
<td>5</td>
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<tr>
<td>2062</td>
<td>45</td>
<td>5</td>
<td>5</td>
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<tr>
<td>2067</td>
<td>50</td>
<td>5</td>
<td>5</td>
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<tr>
<td>2072</td>
<td>55</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>2077</td>
<td>60</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>2082</td>
<td>65</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>
• Broad Recognition:
  – Rising cost per beneficiary, not the number or type of beneficiaries that is increasing the costs of care.
Value For Money

Cost vs. Health Outcome
Medicare Spending per Beneficiary in the United States, by Hospital Referral Region, 2008

Source: Data from CMS
Variation in Medicare Spending

Total Medicare Reimbursement
Parts A and B Reimbursement in 2003

Source: Dartmouth Atlas of Health Care
Quality Variation Even within Medicare

Discharges for Ambulatory Care Sensitive Conditions
per thousand Medicare beneficiaries in 2003

Source: Dartmouth Atlas of Health Care
Performance on Medicare Quality Indicators, 2000–2001

Higher Spending Does Not Necessarily Lead to Higher Quality

EXHIBIT 1
Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001

Overall quality ranking

NOTE: For quality ranking, smaller values equal higher quality.

Source: Baicker and Chandra (Health Affairs 2004)
## Variations Among Academic Medical Centers

### Use of Biologically Targeted Interventions and Care-Delivery Methods Among Three of U.S. News and World Report’s “Honor Roll” AMCs

<table>
<thead>
<tr>
<th>Biologically Targeted Interventions: Acute Inpatient Care</th>
<th>UCLA Medical Center</th>
<th>Massachusetts General Hospital</th>
<th>Mayo Clinic (St. Mary’s Hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS composite quality score</td>
<td>81.5</td>
<td>85.9</td>
<td>90.4</td>
</tr>
</tbody>
</table>

### Care Delivery—and Spending—Among Medicare Patients in Last Six Months of Life

<table>
<thead>
<tr>
<th>Total Medicare spending</th>
<th>50,522</th>
<th>40,181</th>
<th>26,330</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days</td>
<td>19.2</td>
<td>17.7</td>
<td>12.9</td>
</tr>
<tr>
<td>Physician visits</td>
<td>52.1</td>
<td>42.2</td>
<td>23.9</td>
</tr>
<tr>
<td>Ratio, medical specialist / primary care</td>
<td>2.9</td>
<td>1.0</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Source: Elliot Fisher, Dartmouth Medical School.
Comparative effectiveness research: Definition

The generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition, or to improve the delivery of care.
Purpose of CER

• The purpose of CER is to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels.

Institute of Medicine
The IOM: a national CER program should:

- Do priority-setting on an ongoing basis.
- Have a broadly representative oversight committee.
- Engage public participation at all levels of CER.
- Support large-scale, clinical and administrative data networks.
- Do research on dissemination of CER findings.
- Support research and innovation in the methods of CER.
- Expand and support the CER workforce.
Does Comparative-Effectiveness Research Threaten Personalized Medicine?
Alan M. Garber, M.D., Ph.D., and Sean R. Tunis, M.D.

Debate about Funding Comparative-Effectiveness Research
Jerry Avorn, M.D.

The Neglected Purpose of Comparative-Effectiveness Research
Aanand D. Naik, M.D., and Laura A. Petersen, M.D., M.P.H.
New Effort Reopens a Medical Minefield

Tony Coelho, a former House Democratic whip, is helping lead a group warning that the comparative effectiveness movement could lead to inadequate treatment of some patients.

By BARRY MEIER
Published: May 6, 2009

A back-pain researcher, Dr. Richard Deyo recalls the uproar the last time federal officials tried to suggest how doctors should practice their profession.
Then a miracle occurs

P06511
HAQ 10+t
n=1.

"I think you should be more explicit here in step two."
Investigators, Industry, Payers and Policymakers

- Patient Reported Outcomes and Public Perspective
- Medical Management Cohorts
- CERTN Learning System
  - Outpatient Care Re-admissions and Costs
  - All 6 payers/insurers
  - Medication Use
  - Informatics tool

SCOAP Quality Improvement

- Vascular
- Pediatric
- Bariatric
- Appy
- Colon Rectal
- Spine
- Cancer
- GYN
- Urology

Clinicians and Hospitals
Paths Toward Capturing the Opportunity

- **Information**
  - Comparative effectiveness research
  - Randomized control trials
  - Health Information Technology
  - Cost offsets and ROI
- **Incentives**
  - Better care, not more care
  - Coverage vs. differentiated payments
- **Delivery Systems**
- **Health Behavior**
  - Making it easy and simple to lead healthy lives
  - Managing chronic disease
  - Emphasizing prevention
  - Changing behavior and social norms among medical professionals
References


Find out more:

www.scoap.org