U.S. Healthcare Spending: International Context, National Trends, and Getting to High-Value Care

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Agenda

- International context: how does US spending and utilization compare with other countries?
- How did the ACA try to address our cost and quality problems? Has it worked?
- What does this mean for MA?

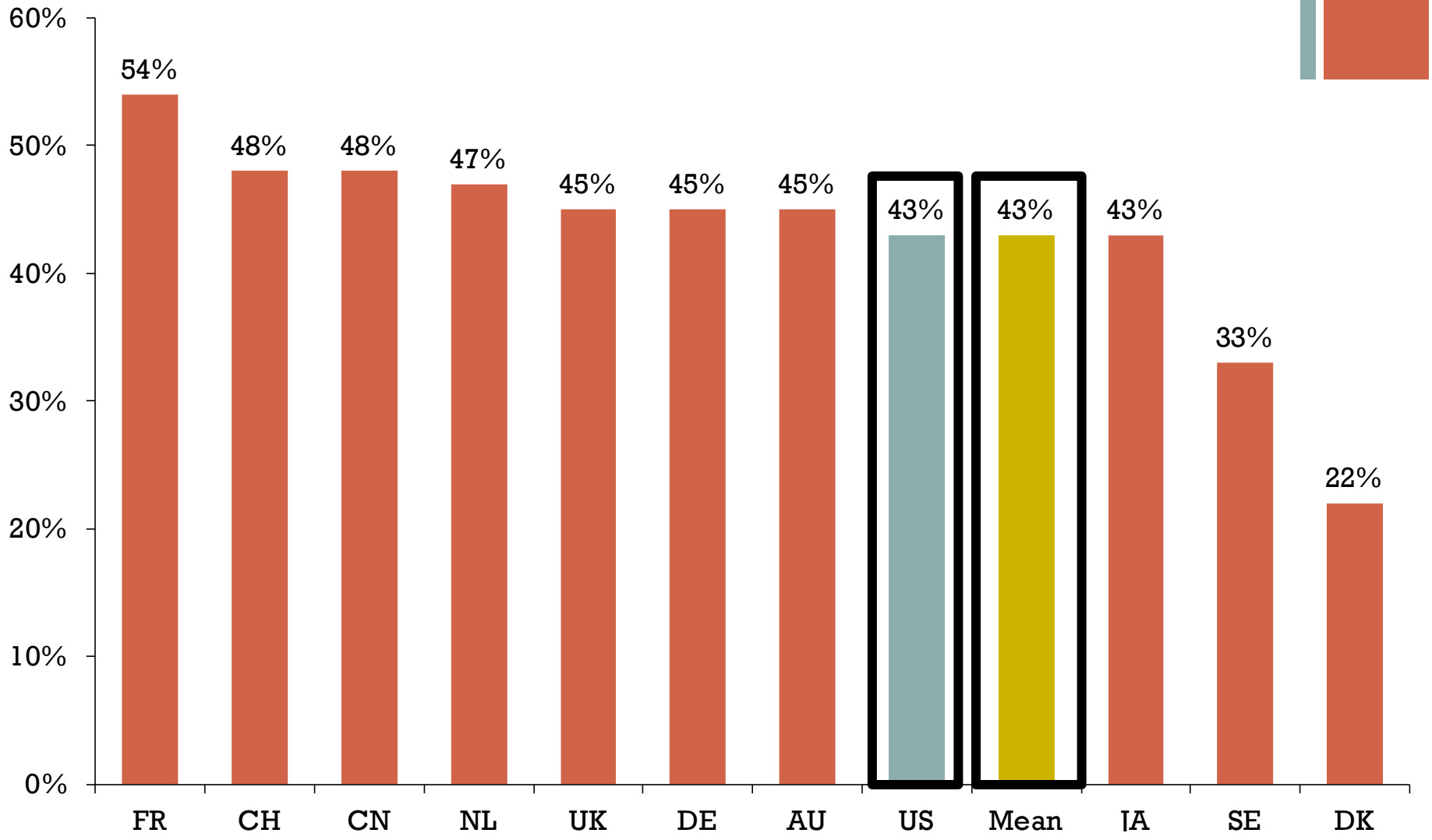
+ How does US spending compare to other countries?

Total healthcare spending, 2016

Why?

Hypothesis #1: Too many specialists, not enough primary care

Primary care as % of MDs



Total Spending = Quantity X Price

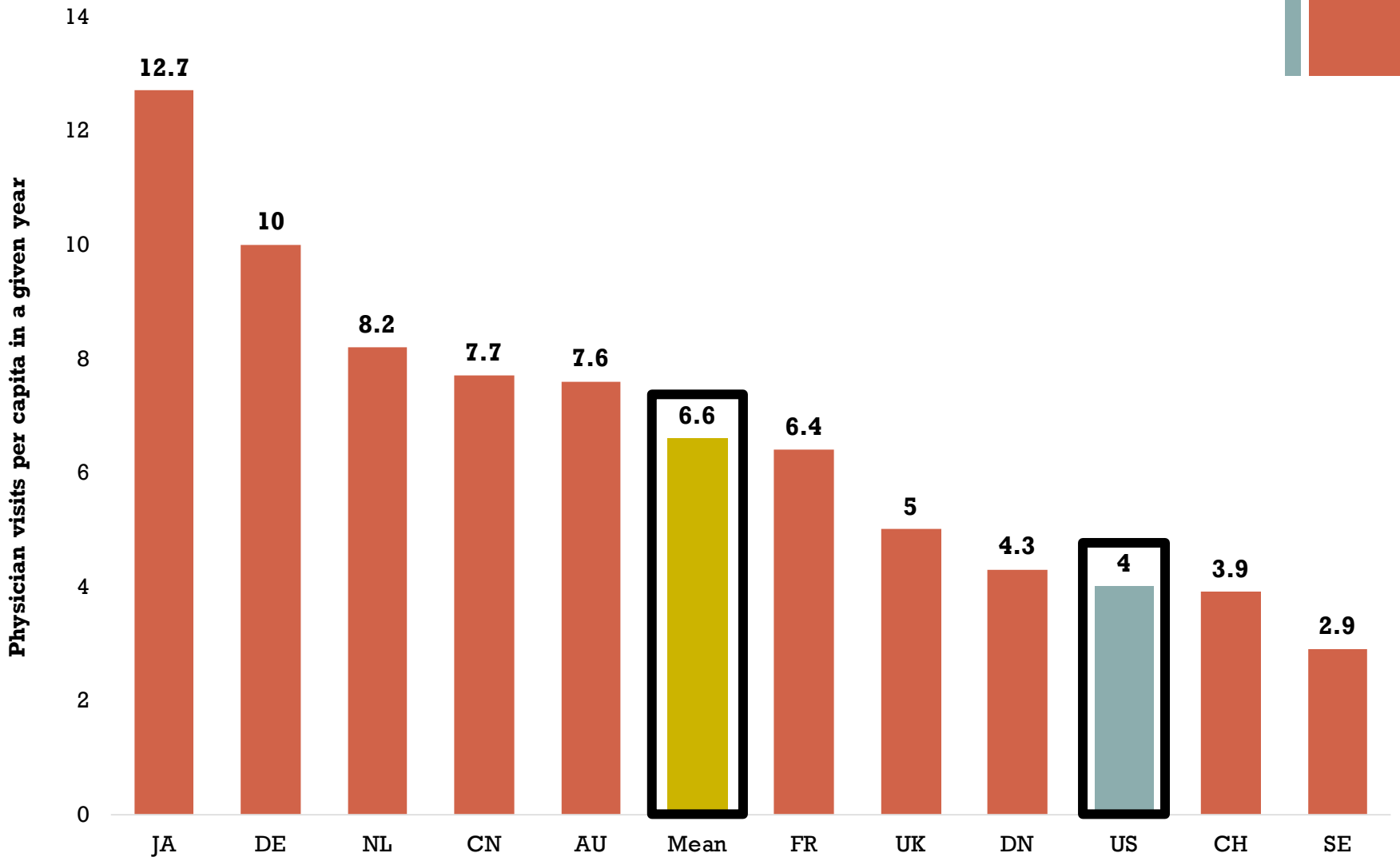
Our culture of overuse

Total Spending = Quantity X Price

Overutilization theory #1

We are quick to go to the doctor

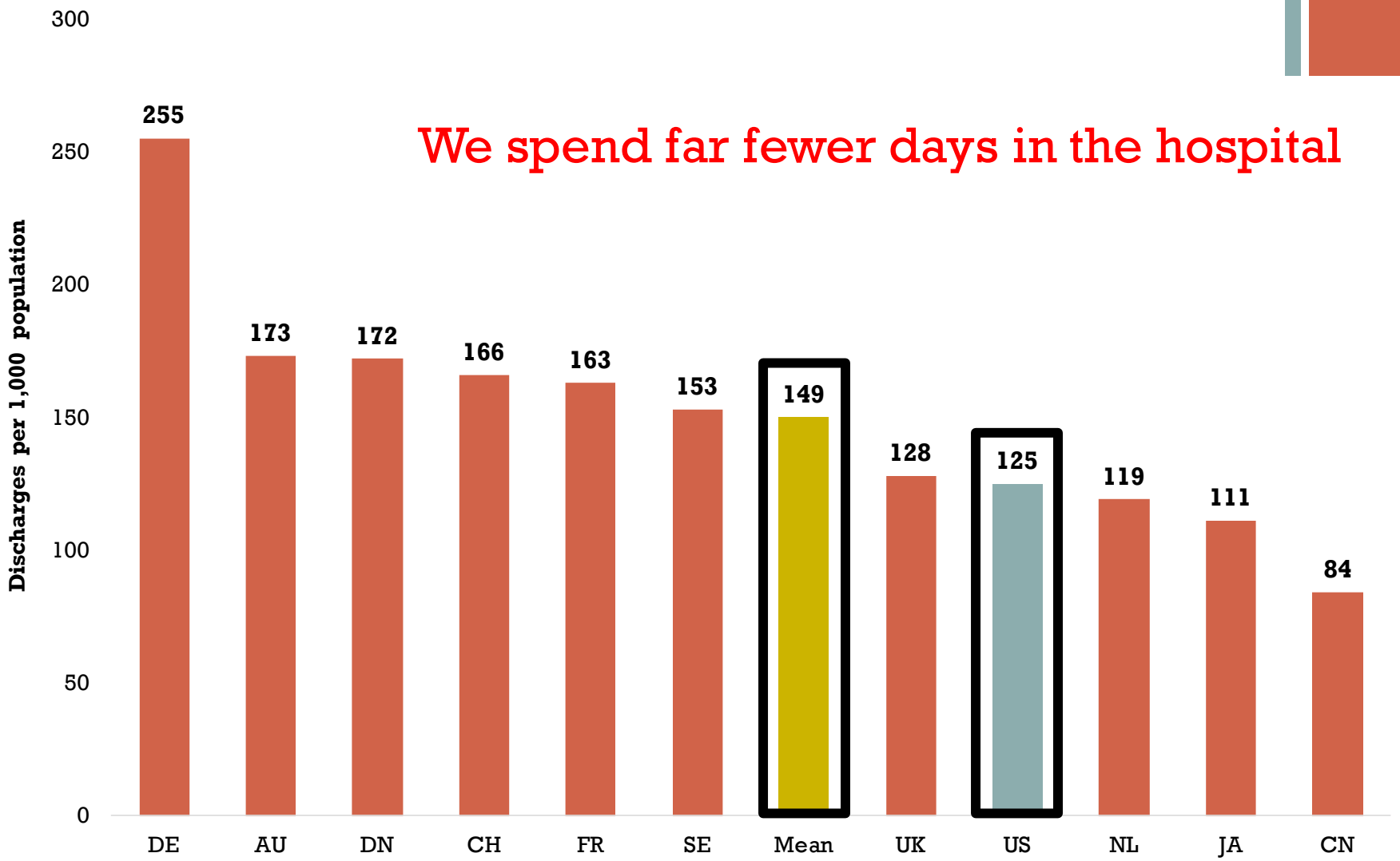
Doctor visits



Overutilization theory #2

Not enough prevention and primary care leads to too many hospitalizations

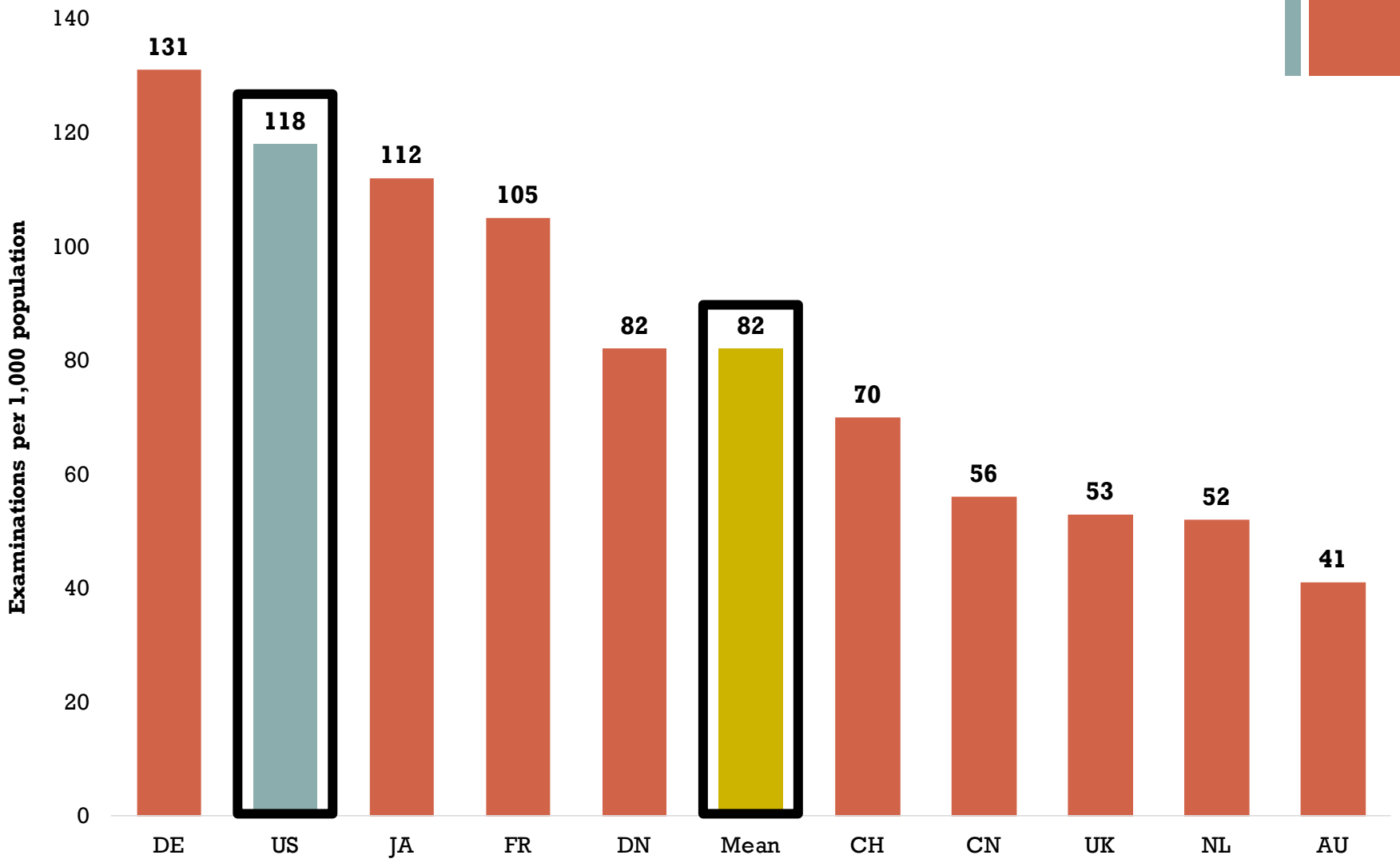
Hospital discharges



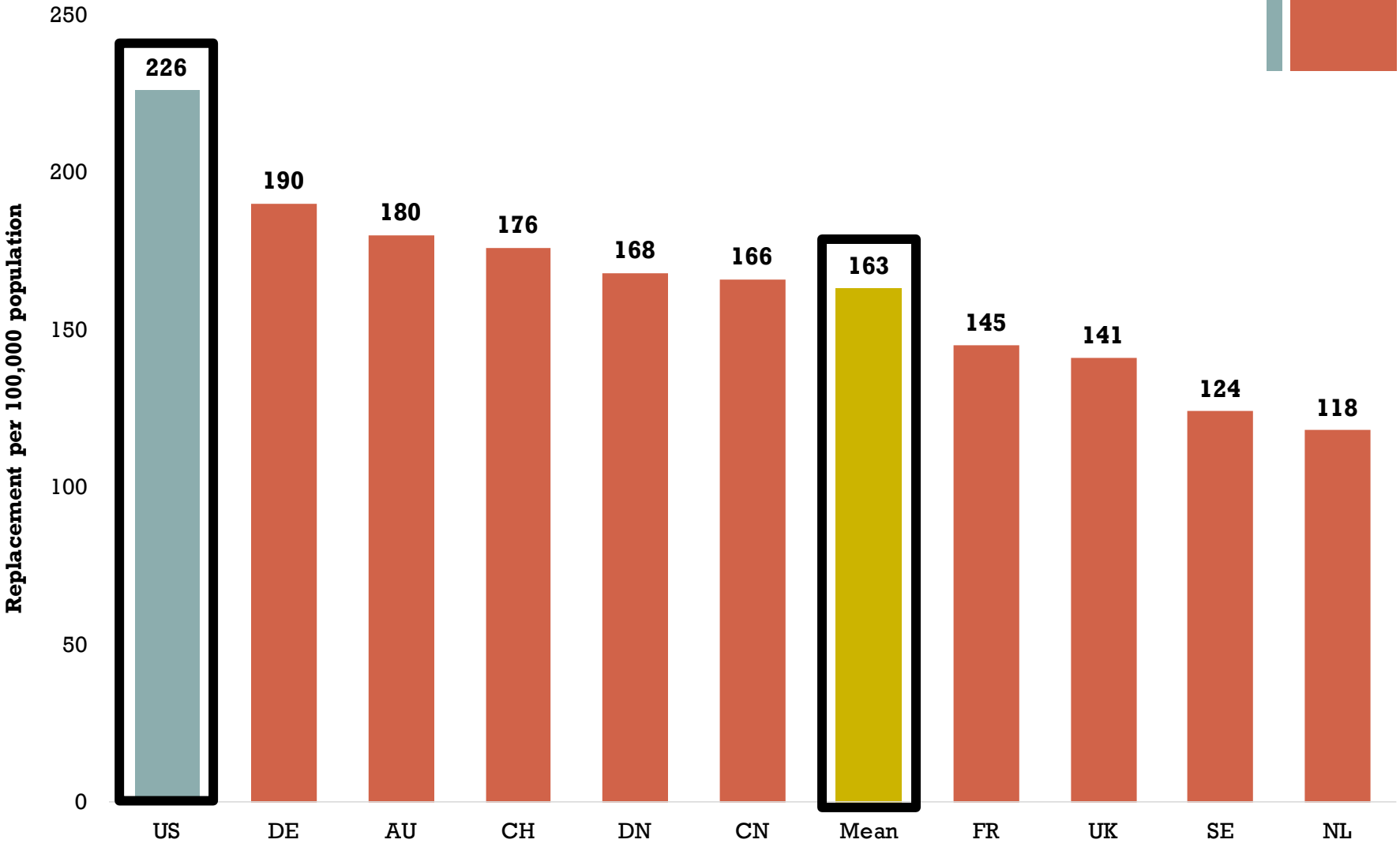
Overutilization theory #3

We use too many tests and procedures

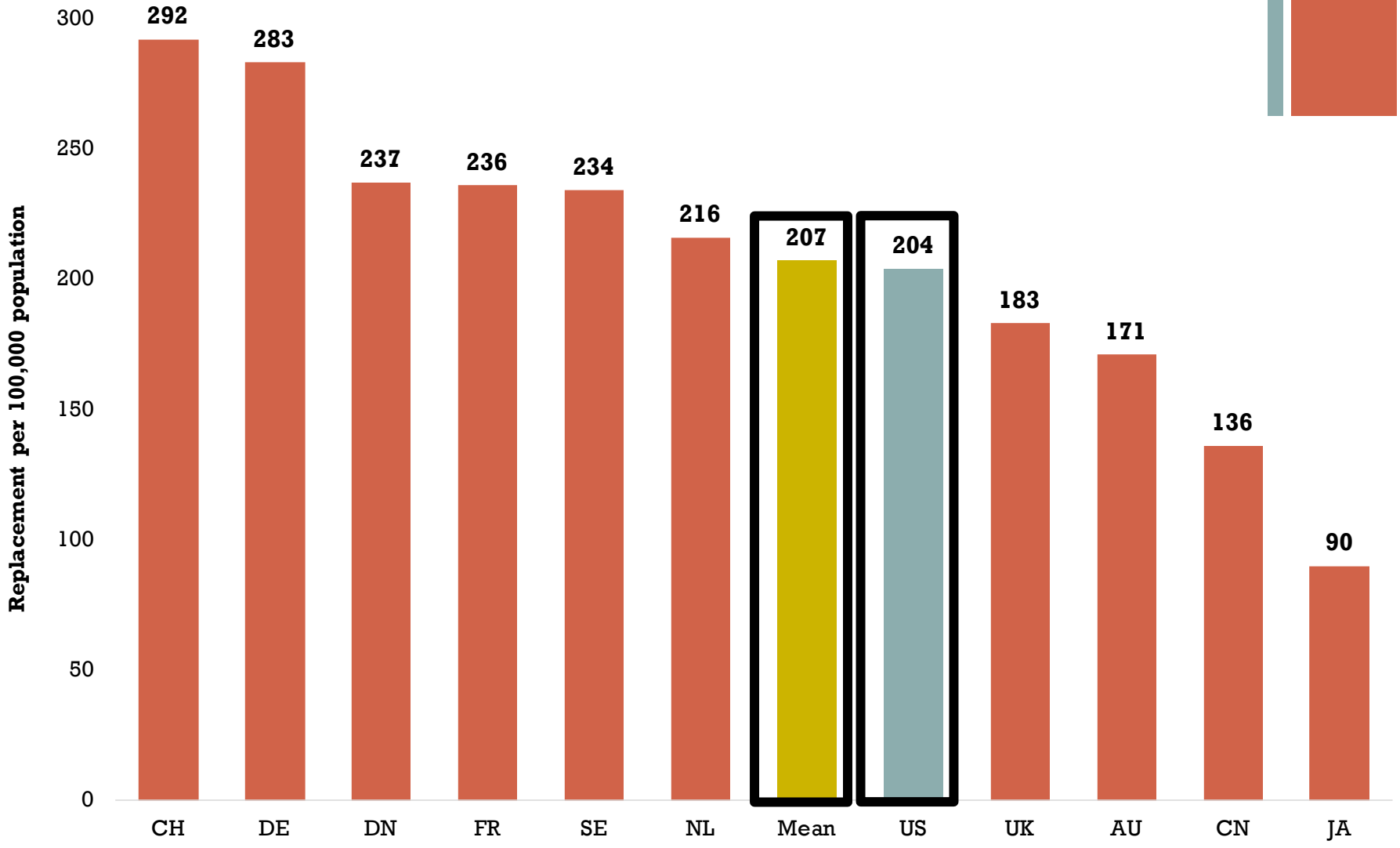
MRI examinations



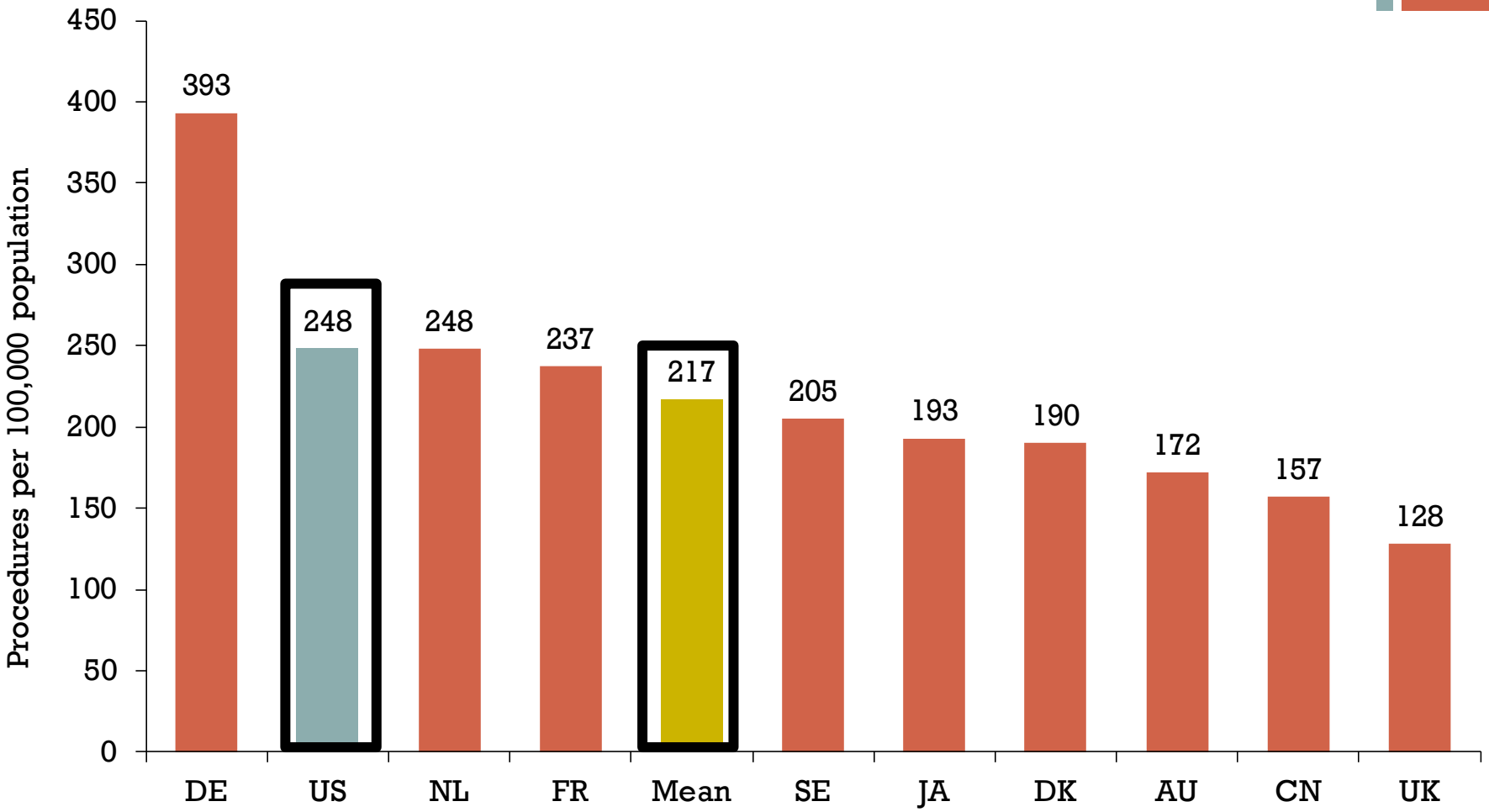
Total knee replacement



Total hip replacement



Coronary angioplasty



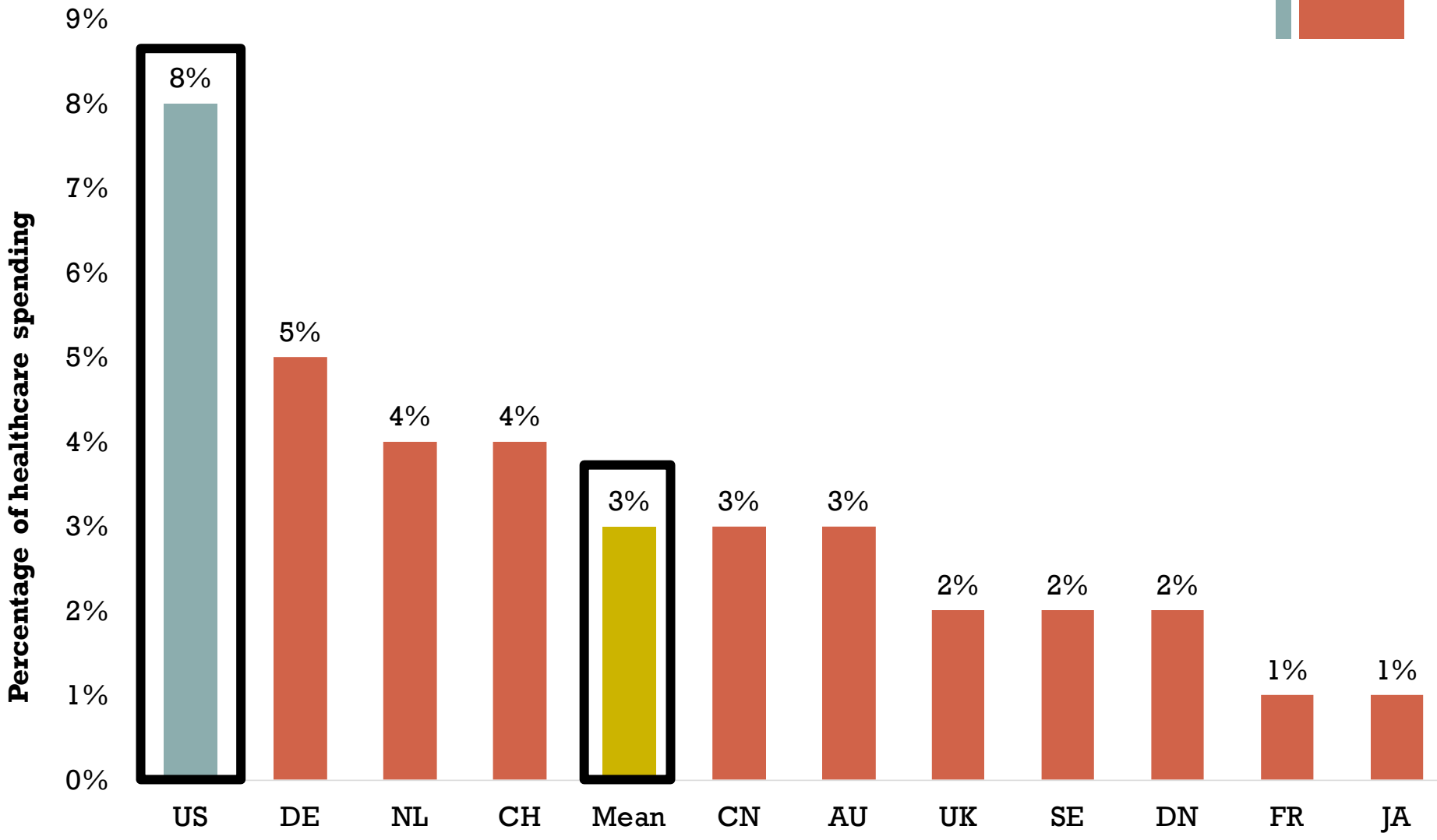
So is it utilization?

- Higher US costs not primarily about utilization
- We have fewer hospitalizations, doctor visits
- Tests and Procedures a mixed bag:
  - We do a lot more MRIs, TKRs, Angioplasties
  - We do fewer hip replacements
- Bottom line:
  - We're above average on some things
  - We're below average on other things
  - On average, we are pretty average

+ OK– so what is it?

Administrative waste

Governance, administration spending



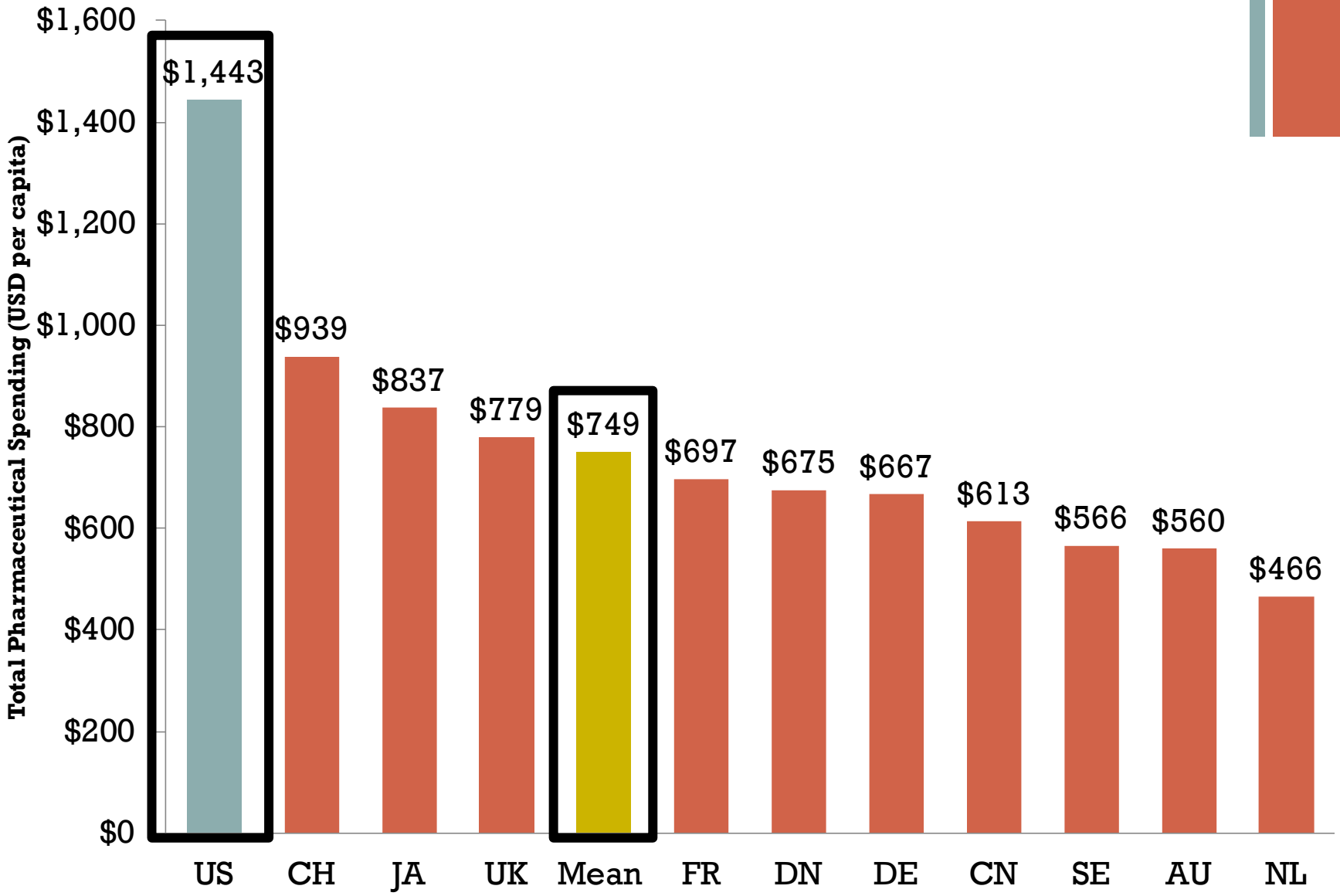
Total Spending = Quantity X Price

Prices

Prices of what?

Pharmaceuticals!

Total Spending (USD Per Capita)

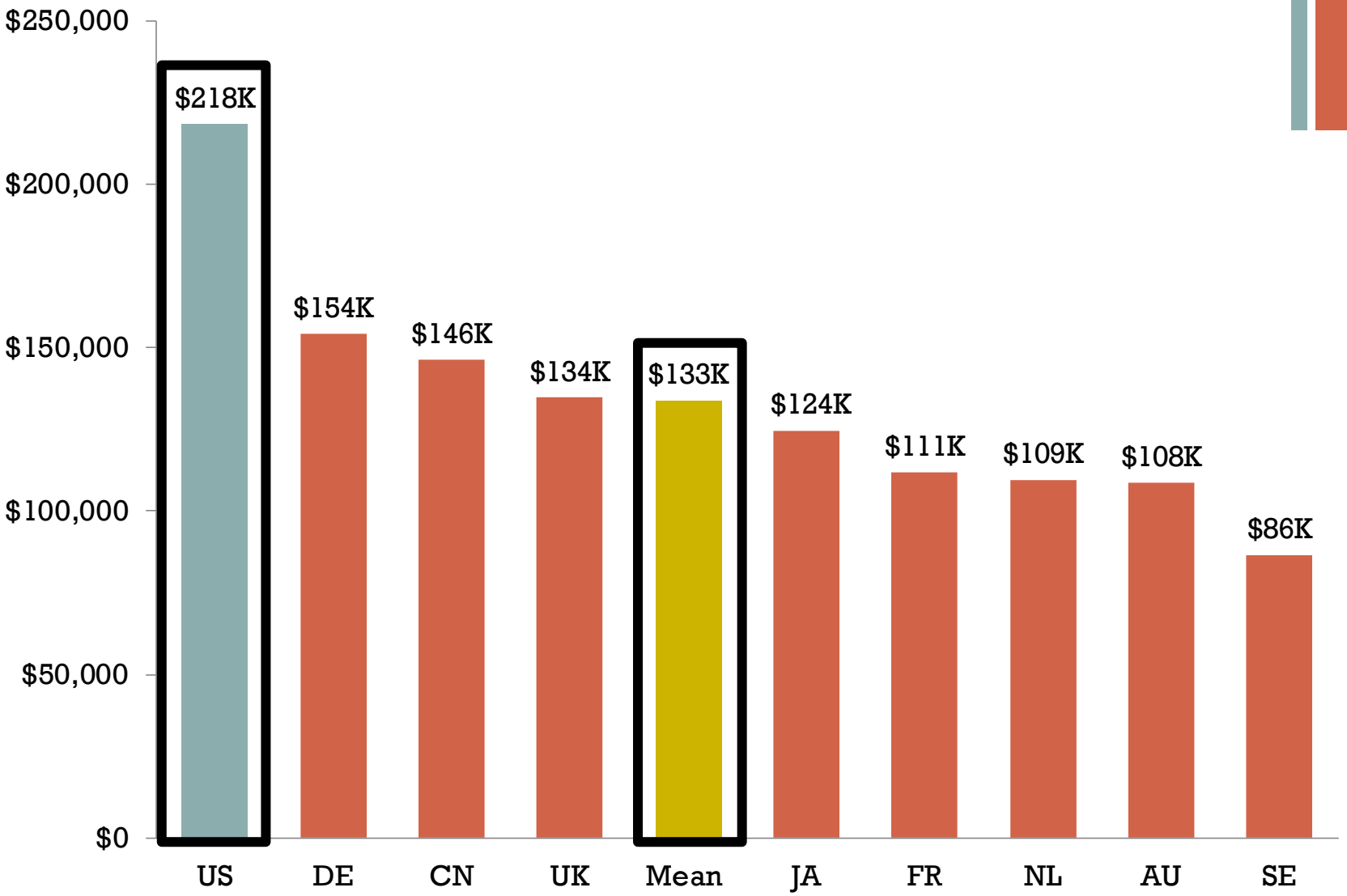


+ Pharma makes up about 15% of all HC spending

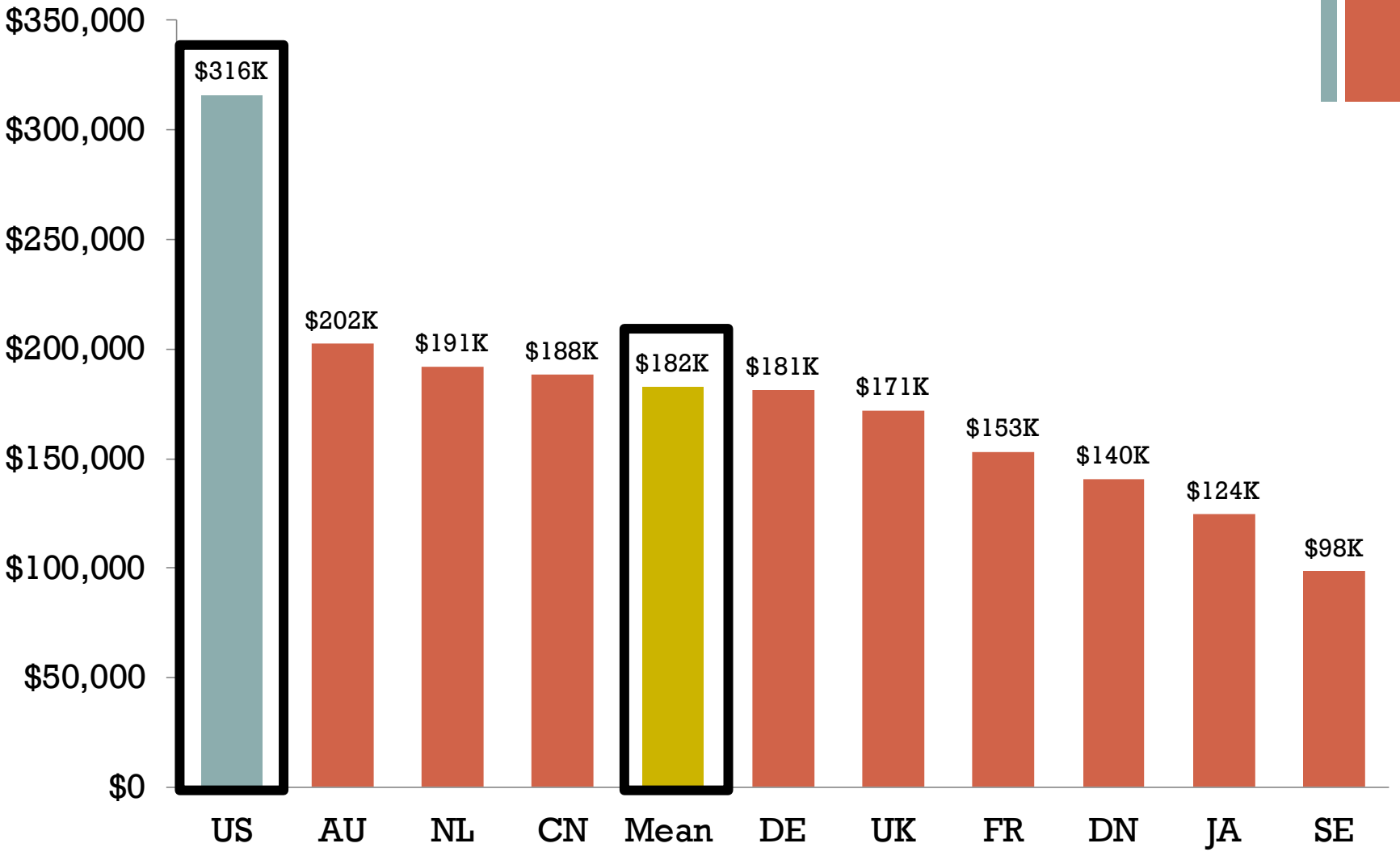
+

So that can't be the whole story

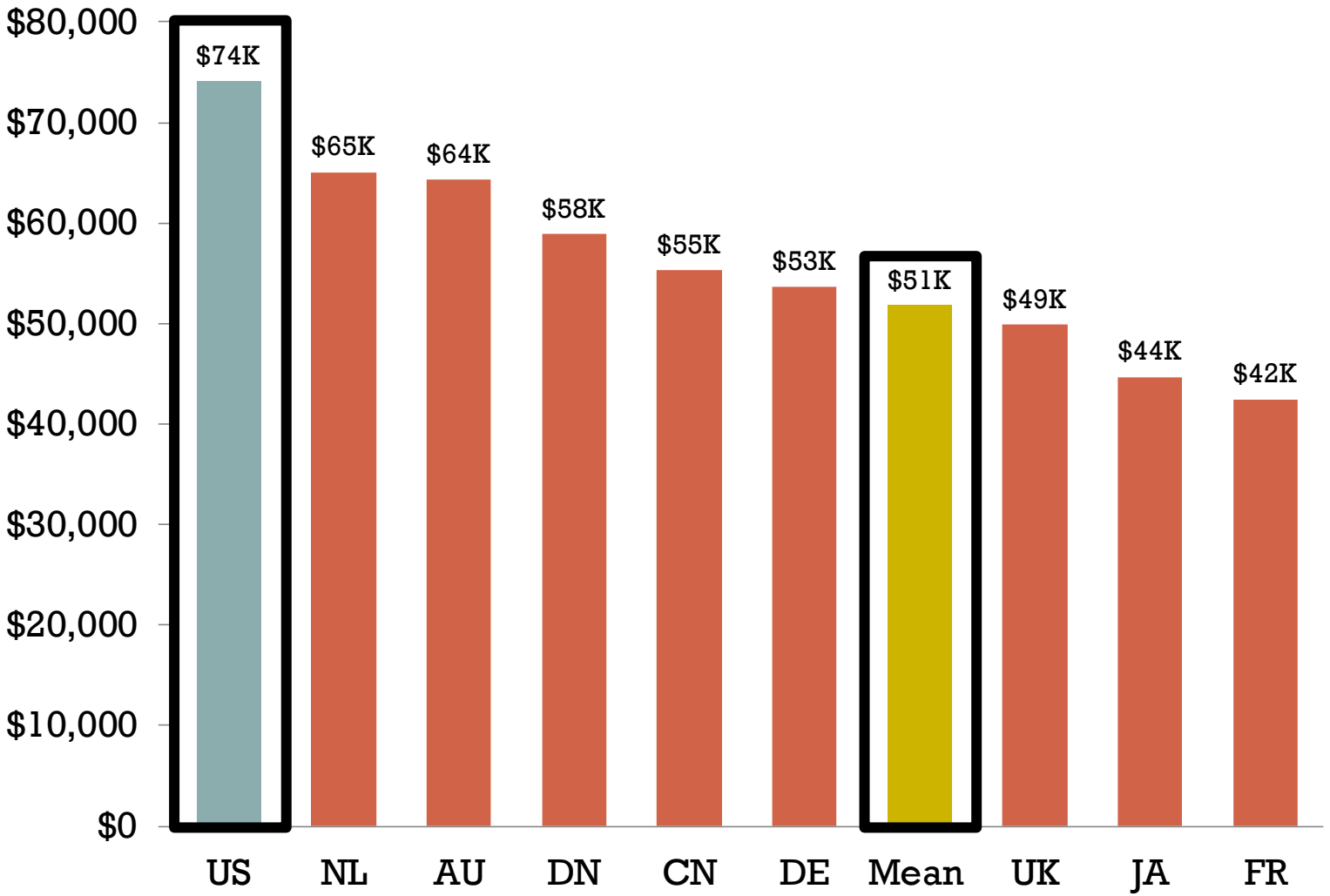
Generalist Physician Salaries



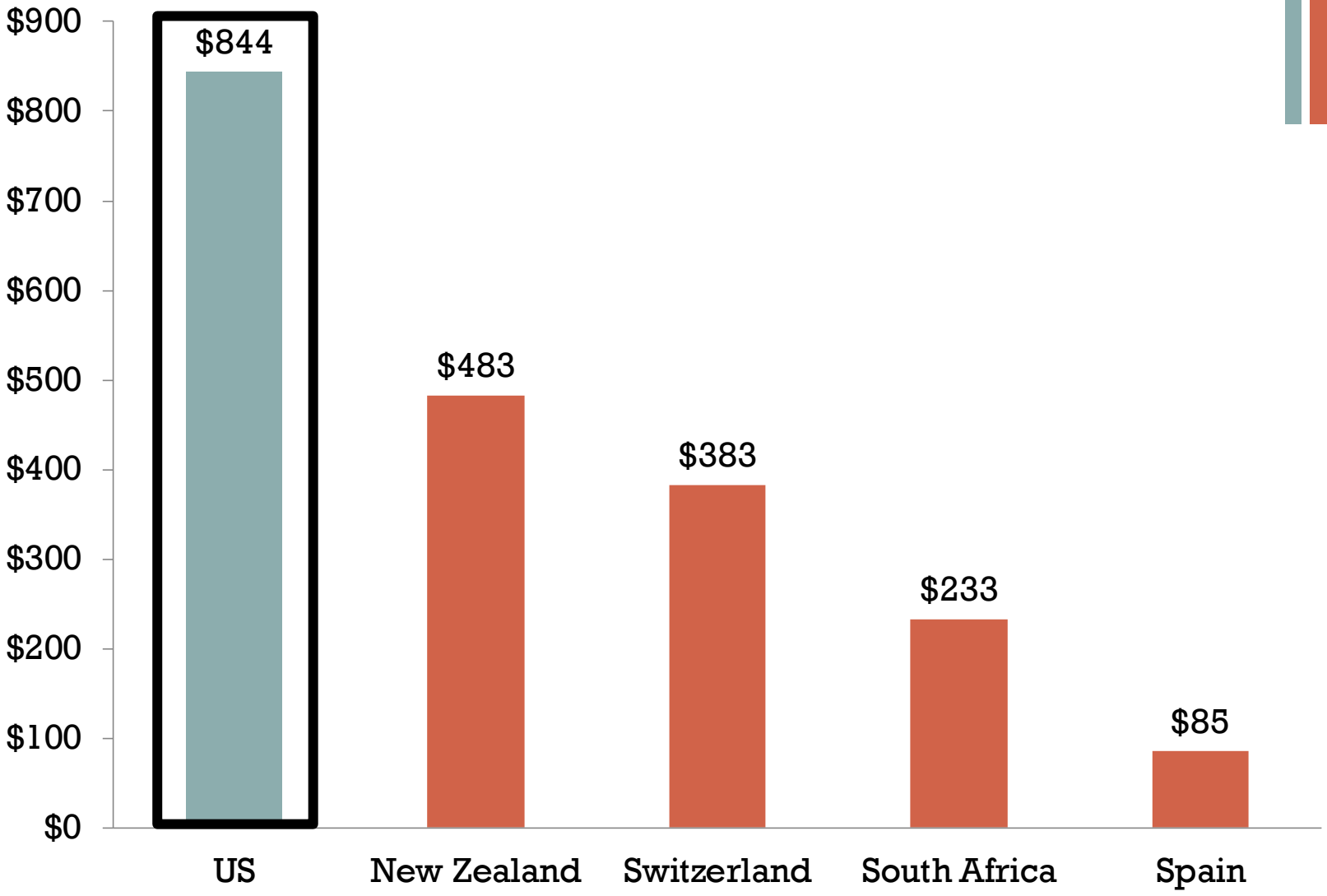
Specialist Physician Salaries



Nurse Salaries



CT Scan Abdomen



International Federation of Health Plans 2015

Appendectomy

International Federation of Health Plans 2015

So what makes US HC so expensive?

Summary

- Hypotheses unlikely to explain difference:
  - Primary care/specialist mix
  - Overutilization
- High costs driven primarily by:
  - Administrative costs
  - High prices
- We can still save money by reducing quantity

What have we largely focused on?

Total Spending = Quantity X Price

Causes of our system dysfunction

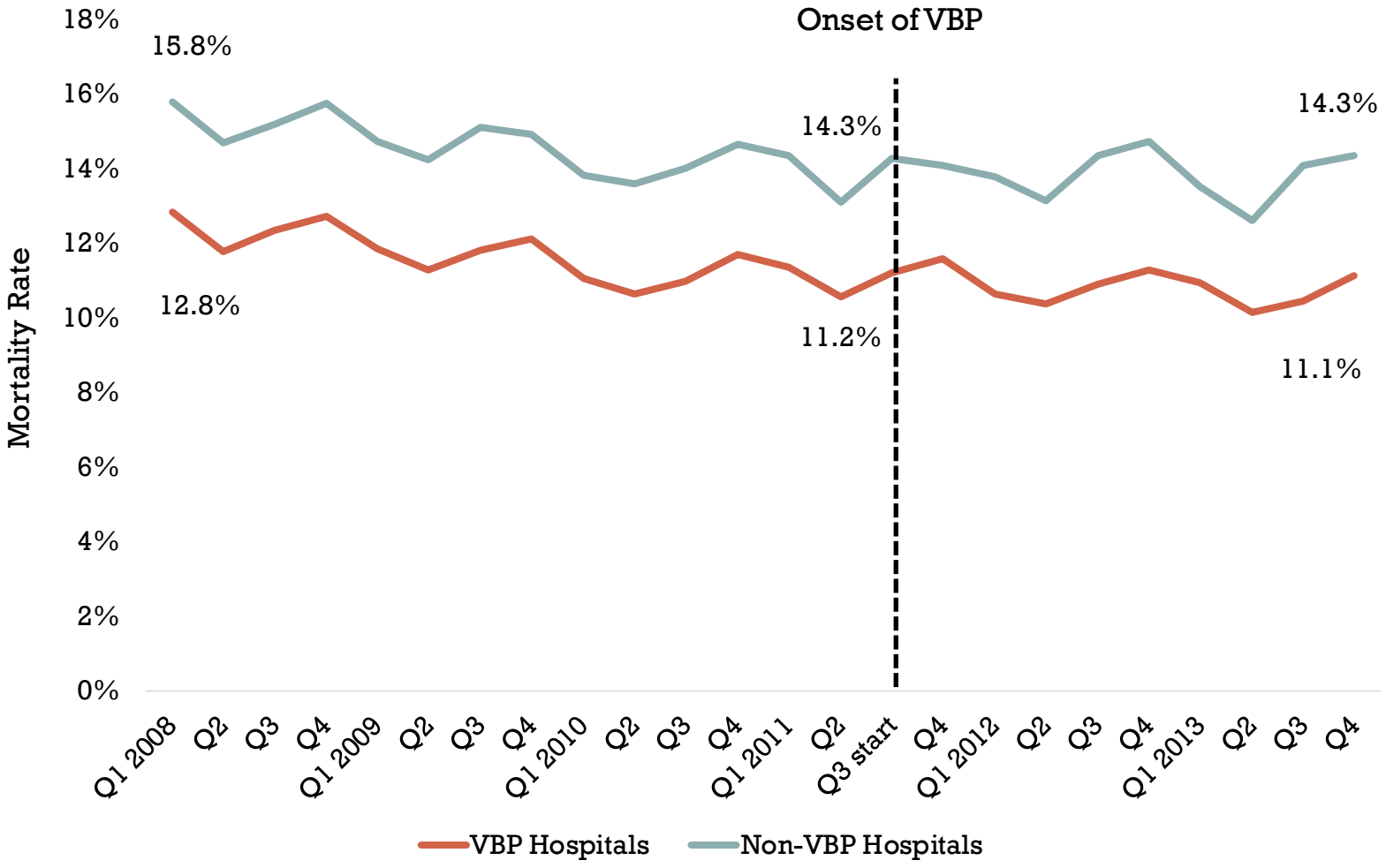
- Fragmentation
- How we pay for care (FFS, lack of incentives)
- Inadequate transparency
- Inadequate competition
- Inadequate patient "skin in the game"

What did the ACA do to fix things?

- Change how we pay for things
  - Hospital readmissions reduction program
  - Value-based purchasing
- Hold providers accountable
  - Patient-centered medical home
  - Accountable Care Organizations
- Centrally manage innovation
  - CMMI
- Investment in Health IT

+ So has the ACA worked?

Value-based payment has had little effect



Figueroa et al. BMJ 2016

Value-based payments in hospitals

- Readmission rates have fallen about 2.5%
  - About 2/3 of that is due to coding
  - Some (weak) evidence that it made mortality worse
  - Impact overall quite controversial

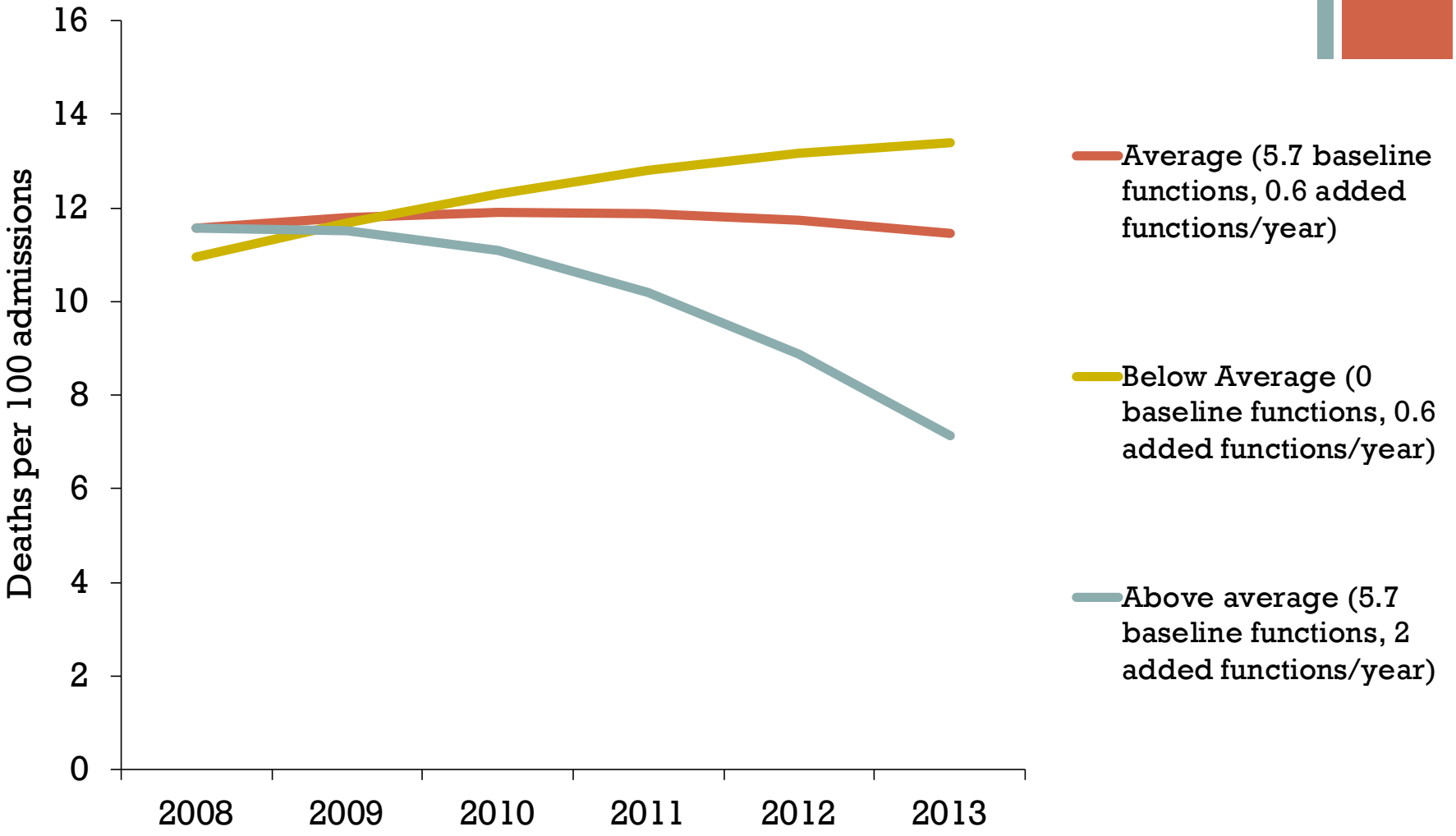
Ibrahim et al. JAMA Internal Medicine 2017; Gupta et al. JAMA Cardiology, 2017; Jha & Pronovost, NEJM, 2015

Primary Care Initiative (CPCI)

- CPCI targeted 502 primary care practices in 7 U.S. regions
  - Spending did not decrease enough to cover care management fees
  - After 4 years, no change in overall spending growth, modest impact on quality
    - 2% lower growth in ED visits

Peikes et al Health Affairs 2018

EHR impact on mortality, 2008-2013

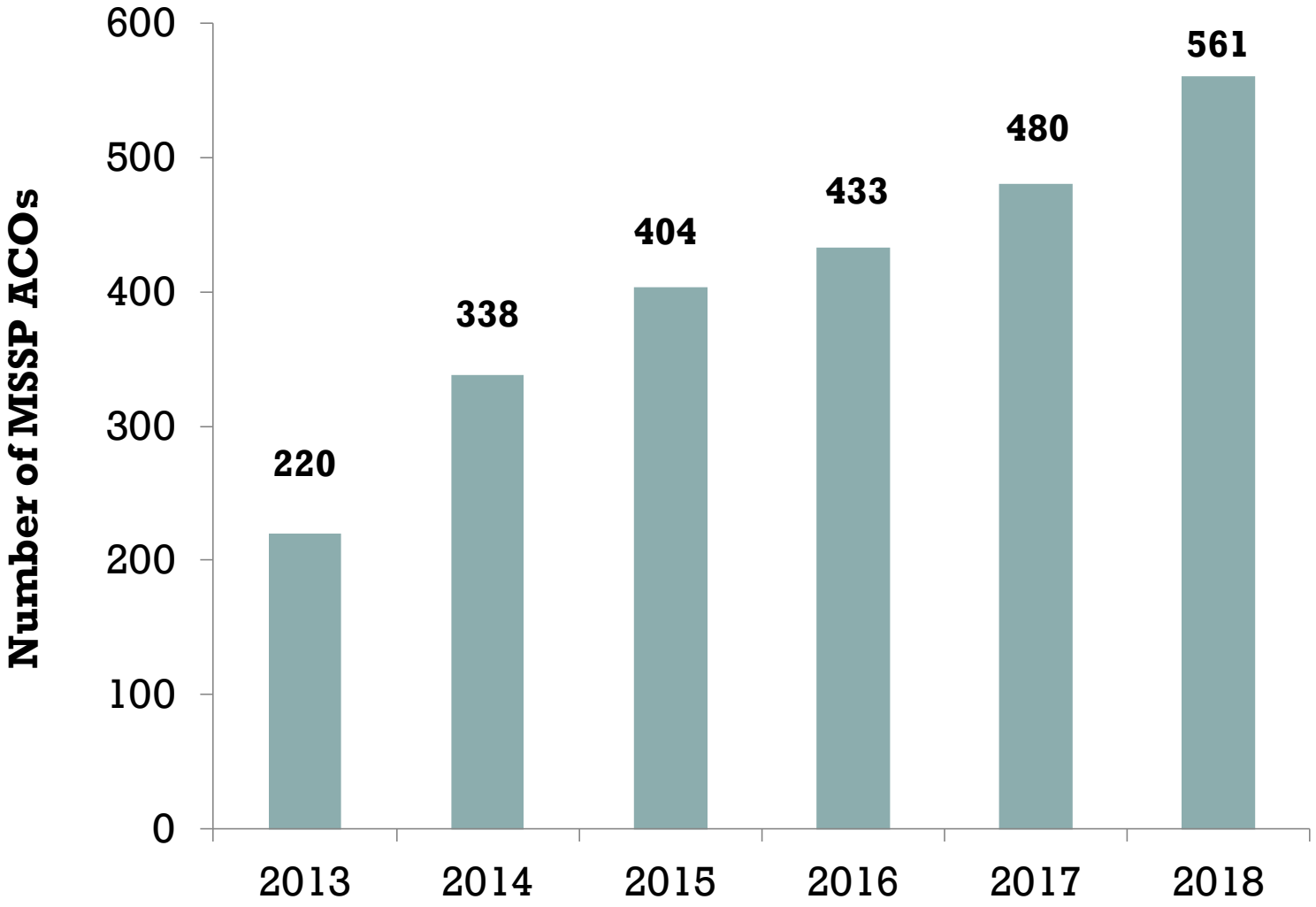


Bundled Payments

- The findings are mixed
  - **For medical conditions:** no change in spending or quality
  - **For surgical conditions:** associated with decreases in spending and small quality improvements
    - 4%-20% decrease in per-episode spending for joint replacement
- Why?
  - Different spending patterns
  - Different services provided in post-acute settings
  - Different types of patients

Dummit JAMA 2016, Joynt et al NEJM 2018, Navathe JAMA 2017, Navathe Health Affairs 2018

Number of ACOs continues to grow



Center for Medicare and Medicaid Services

Impact of ACOs on Quality & Cost

- How are they doing? Two alternative views:
  - McWilliams et al. consistently find 2-5% savings, by cohort:
    - 2012: 4.9%
    - 2013: 3.5%
    - 2014: 1.6%
- Impact on quality?
  - A few positive changes in pt experience, little on outcomes
- All the savings are in physician-led ACOs

McWilliams NEJM 2018

A summary of where we have been

- ACA spurred LOTS of activity
- Some of it is making a real difference
- Much of it has focused on quantity
  - Medicare led
  - Prices are fixed
  - Relative prices are not…

What's next?

- Push towards price transparency
- Payment Reform:
  - More risk to providers
    - Bundled payments, ACOs, Capitation
- More risk to payers (from CMS):
  - MA
- More engagement of consumers
  - Tiering coming to Medicare?
- Some efforts on prices
  - But probably not enough

What does this mean for MA?

The future of MA healthcare

- Value-based care is important
  - Promote more bundles
  - Promote more ACOs
  - Intensively study which models work and don't – and adjust accordingly
- Value-based strategies not nearly enough
- We must deal with the 800 pound gorilla: prices
  - Price regulation versus competition

Thank you

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