

# Healthcare Policy and Finance 101

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**Bozeman Deaconess  
HOSPITAL**



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# Preview

- History
  - Pricing and payment
  - Private and Public
- Quality
  - International comparison
- Value



# What is this?





# Hint?



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# Code of Hammurabi

The origin of discriminatory pricing and tort reform

- Enacted in 1772 B.C. by Hammurabi, the sixth king of Babylon
- 282 laws including way physicians were paid for their services as well as penalties for poor care
  - §215-217 If a surgeon has made a deep incision in the body of a gentleman with a lancet of bronze and saves the man's life or has opened a carbuncle in the eye of a man with a lancet of bronze and saves the eye, he shall take 10 shekels of silver. If the patient is a freeman, he shall take 5 shekels of silver. If the patient is a slave, the master of the slave shall give 2 shekels of silver to the surgeon. (For reference a free craftsman earned 10 to 14 shekels per year)
  - §218 If a physician operate on a man for a severe wound with a bronze lancet and cause the man's death, or open an abscess in the eye of a man with a bronze lancet and destroy the man's eye, they shall cut off his fingers.





# Why are we talking about this?



# Why are we talking about this?

- Because, after almost 4000 years of “progress” we’re still trying to get it right





# Pre-20<sup>th</sup> Century

- Prior to the early 20<sup>th</sup> Century Healthcare was strictly fee for service and discriminatory pricing was the norm
  - “Science” was primitive
    - Cleanliness, good diet, basic surgery, good nursing and prayer
  - Cost was negligible compared to financial impact of lost wages



# Early 20<sup>th</sup> Century

- The first quarter of the 20<sup>th</sup> Century was the turning point for advances in Medical Sciences
  - First push for quality and consistency in medical education
    - AMA raised educational, licensing and credentialing requirements
      - Consequence was a drop in number of medical school and physicians
  - Effective treatments established
    - 1923: Eli Lilly develops technique to produce insulin in mass quantities
  - Improvements led to better outcomes and more demand
    - Market based economics took their standard course





# Blue Cross

- Birth of the Medical Insurance (Non-profit)
  - 1929
    - Dallas-based teachers formed a partnership with Baylor to provide a set amount of sickness and hospitalization days in exchange for a fixed, prepaid fee
    - At first premiums are not risk based
  - 1939
    - AHA adopts Blue Cross as standard
    - States allow Blue Cross to operate as non-profit
  - 1960
    - Multiple similar programs merged to form Blue Cross



# Blue Shield

- In the next decade physicians follow suit
  - Largely due to the threat of Blue Cross and a looming alternative public health system after the passage of the Social Security Act in 1935
  - 1939
    - First pre-paid physician services plan starts in California
  - 1946
    - Blue Shield formed after several physician plans merge
  - System still allows discriminatory pricing and balance billing
- Blue Cross and Blue Shield merge in 1971





# Government Regulation

- Tax Incentives
  - 1942 Stabilization Act
    - Imposed price controls on employers by limiting employee wage increases
    - Allowed provision of health insurance as a pre-tax benefit
  - 1954
    - Health insurance premiums made deductible to employers
- Most patients eventually have employer based health insurance
  - Packages covering even trivial medical expenses become the norm



# Impact of Big Blue and Tax Incentives


- Payment innovation stagnates
  - Cost plus payment and “reasonable and customary” become the norm
- Difficulty for competition to succeed given tax advantages
- Consumer responsibility diminishes
  - Cost curve is disrupted
  - Utilization increases
- 1939 – 6% of U.S. has hospitalization coverage
- 1970 – 86% of U.S. has hospitalization coverage
  - 46% provided by Blue Cross

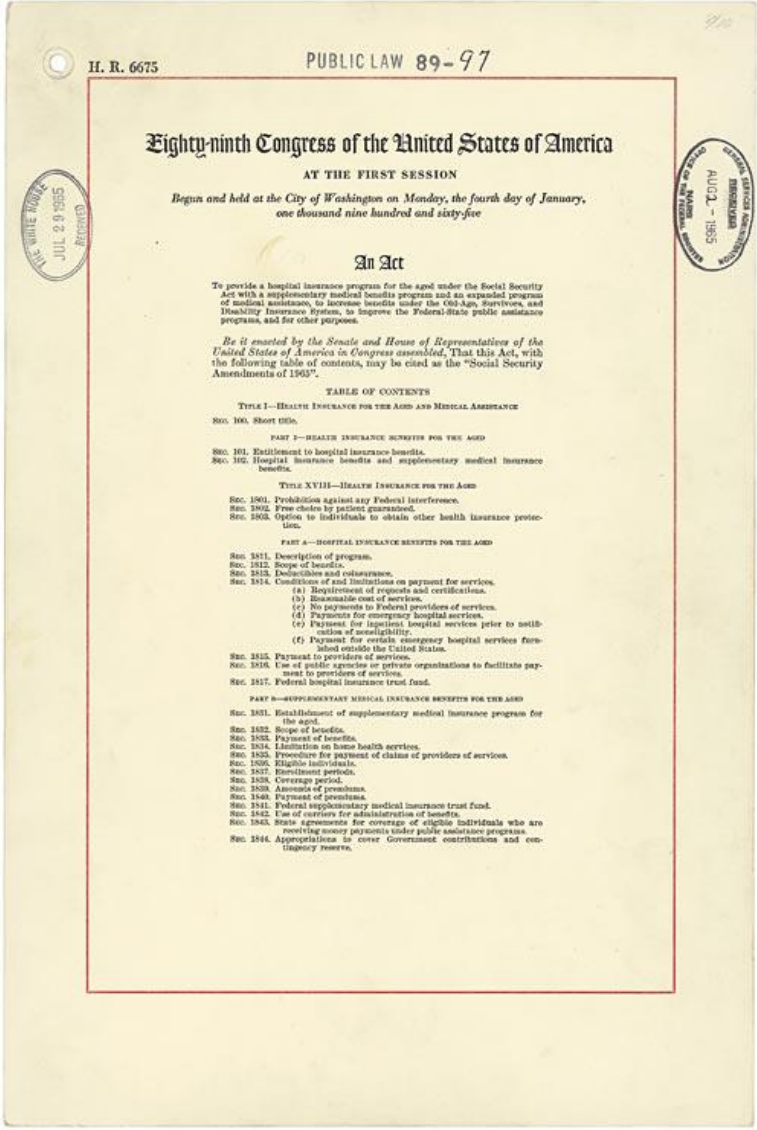




# Who are these people and what are they doing?



|   |                                 |
|---|---------------------------------|
| <b>Health Insurance</b>   |                                 |
| <b>SOCIAL SECURITY ACT</b>  |                                 |
| NAME OF BENEFICIARY<br><b>Harry S. Truman</b>   |                                 |
| CLAIM NUMBER<br><b>488-40-6969A</b>   | SEX<br><b>M</b>                 |
| IS ENTITLED TO<br><b>Hospital Insurance</b>   | EFFECTIVE DATE<br><b>7-1-66</b> |
| <b>Medical Insurance</b>  | <b>7-1-66</b>                   |
| SIGN HERE  |                                 |





# Government Healthcare

- 1965 Medicare Act Passes
  - Initially proposed as catastrophic coverage for hospital care
    - Eventually comprehensive and modeled after BCBS
  - Initially reasonable and customary
    - Eventually transitioned to prospective payment
  - Solidified the concept of patients receiving healthcare and such being paid by someone else
    - Cost sharing being minimal only serves to further increase utilization beyond employment years



# Escalating Cost

- By late 1970's cost of Medicare is beginning to be realized as non-sustainable
  - New technology
  - New Therapies
  - More patients
  - More providers
- Irony is that Medicare actually funded a lot of this





# CMS Legislation

- 1970's
  - 1973 HMO Act
    - Designed to curb medical inflation
    - By 1996 membership rose to 46%
    - Only problem – Physician works for Insurer, not patient
- 1980's
  - DRG
    - Hospital care transitioned to ambulatory care
    - Very effective in controlling cost
    - “Quicker but sicker”



# CMS Legislation

- 1992
  - RBRVS (Resource-based relative value scale)
    - Product of a CMS funded study by a Harvard Professor of Public Health
      - Published in JAMA, September 29, 1988.
    - Data based on surveys of thousands of U.S. Physicians
    - First time “price fixing” imposed upon physicians
    - No balance billing allowed
    - Non-negotiable
    - Signed into law through the Omnibus Budget Reconciliation Act of 1989 by George H.W. Bush.
  - Private insurers eventually adapt system as well
  - Currently, the entire U.S. health system is essentially regulated by DRG and RBRVS payment models





# RBRVS

- AMA sets CPT
- AMA/Specialty Society Relative Value Scale Update Committee (RUC)
  - Expert panel that develops relative value recommendations to CMS.
- CMS
  - CMS is mandated to make appropriate adjustments to the new RBRVS in response to the Omnibus Budget Reconciliation Act of 1989 to account for changes in medical practice coding and new data and procedures.
- Converter
  - 1/1/2015 – 3/31/15 = \$35.8013
  - 4/1/15-12/31/15 = 28.2239 (drop of 21.2%)

– Since 1994, only 2011 was lower



# CMS Legislation

- 1997 Balance Budget Act
  - SGR
    - Generally, this is a method to ensure that the yearly increase in the expense per Medicare beneficiary does not exceed the growth in GDP
    - Consistently overridden due to obvious being a non-practical solution to cost control
  - Part C (Gap Insurance)
- 2003 Medicare Modernization Act
  - Part D (Drug Coverage)





# Quality

- U.S. Institute of Medicine
  - The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge
- U.S. Agency for Healthcare Research and Quality
  - Doing the right thing at the right time in the right way for the right person and having the best results possible



# Quality Dimensions

- Effectiveness
- Acceptability
- Accessibility
- Appropriateness
- Care environment and Amenities
- Competence or Capability
- Continuity
- Cost
- Efficiency
- Equity
- Governance
- Patient focus
- Safety
- Sustainability
- Timeliness





# Why Now?

- U.S. per capita cost and %GDP for healthcare dwarfs all other developed nations,
- We are not as good as we think we are when compared to other developed nations
  - Worst performer in a study of 19 countries for death rate from preventable or treatable conditions
  - Mixed data on comparison of preventative care
  - Mixed data on management of chronic conditions
  - Highest rates of safety concerns
- Note that there are some very valid criticisms of all of these studies pertaining to methodology and bias



# VALUE

Value = Quality + Safety + Access + Efficiency  
Cost

- Provide the **best care** possible with modern technology as **soon as possible** while **minimizing resource utilization** and **eliminating potential harm**, all for **less than you currently charge** for similar services





# What is this??



# Patient Protection and Affordable Care Act

(aka ACA or Obamacare)

Largest expansion of Government Healthcare and associated regulation since 1965

- Expand coverage/access
- Improve quality
- Reduce cost
  - Independent Payment Advisory Board (IPAB, aka “death panel”
    - » Action only if Medicare spending is 1% or more above CPI.
    - » 5-year rolling average of Medicare spending, including predictions for the 2 upcoming years.





# Alternative Payment Models

- Accountable care organization (ACO)
- Bundled Payments
  - Medicare Networks



# Pay to Play/Perform (or penalty)

- Meaningful use
  - 2% penalty in 2016
- E-prescribing
  - 2% penalty in 2014
- Physician Quality and Reporting System (PQRS)
  - Tax Relief and Health Care Act of 2006
  - 2% penalty in 2016 (off of 2014 data)
- Value based Payment Modifier
  - ACA
  - Outcomes, Patient Experience, Quality, Cost
  - 2% Penalty in 2016





# How would Hammurabi put it

- 4000 years later . . .
- If a physician provides exceptional care, but fails but fails to document and report such exactly as dictated by CMS, including only using mandated tools and methods, they get to keep their fingers. (Note, no shekels are paid for such services).

