Why is U.S. healthcare spending so high?  
What we can and can’t learn from international comparisons

Ashish K. Jha, MD, MPH
January 10, 2019
@ashishkjha
Agenda

- We spend a lot on healthcare
- Why do we spend so much more than others?
- Tradeoffs: what does our higher spending give us?
- What about quality and outcomes?
- How do we think about value in the international context?
- States as laboratories of innovation
US healthcare spending
Why?
+ Why so much *more*?
Health Care Spending in the United States and Other High-Income Countries

Irene Papanicolaos, PhD; Liana R. Woskie, MSc; Ashish K. Jha, MD, MPH

IMPORTANCE Health care spending in the United States is a major concern and is higher than in other high-income countries, but there is little evidence that efforts to reform US health care delivery have had a meaningful influence on controlling health care spending and costs.

OBJECTIVE To compare potential drivers of spending, such as structural capacity and utilization, in the United States with those of 10 of the highest-income countries (United Kingdom, Canada, Germany, Australia, Japan, Sweden, France, the Netherlands, Switzerland, and South Korea).
Our approach:

- Compared US to 10 other very high income countries
- Data source: mostly OECD, some CMWF
- Data verified by national statistics offices and/or experts
Why so much more?
Total Spending = Quantity X Price
Hypothesis #1
“Our culture of overuse”
Total Spending = \text{Quantity} \times \text{Price}
Overutilization #1

“We are quick to go to the doctor”
Physician visits per capita in a given year

<table>
<thead>
<tr>
<th>Country</th>
<th>Visits Per Capita</th>
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<tr>
<td>JA</td>
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<td>SE</td>
<td>2.9</td>
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</tbody>
</table>
Overutilization #2

Not enough prevention and primary care leads to too many hospitalizations
We spend far fewer days in the hospital.
Overutilization #3

We use too many tests and procedures*
MRI examinations

Examinations per 1,000 population

- DE: 131
- US: 118
- JA: 112
- FR: 105
- DN: 82
- CH: 82
- CN: 70
- UK: 56
- NL: 53
- AU: 52
- Mean: 41

Countries: DE (Germany), US (United States), JA (Japan), FR (France), DN (Denmark), CH (Switzerland), CN (China), UK (United Kingdom), NL (Netherlands), AU (Australia)
Total knee replacement
Total hip replacement

Replacement per 100,000 population

<table>
<thead>
<tr>
<th>Country</th>
<th>CH</th>
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<td>204</td>
<td>183</td>
<td>171</td>
<td>136</td>
<td>90</td>
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</table>

Coronary angioplasty

Procedures per 100,000 population

- DE: 393
- US: 248
- NL: 248
- FR: 237
- Mean: 217
- SE: 205
- JA: 193
- DK: 190
- AU: 172
- CN: 157
- UK: 128
Hypothesis #1 Update

- Higher US costs not primarily about providing more care
- We have fewer hospitalizations, doctor visits

Tests and Procedures a mixed bag:
- We do a lot more MRIs, TKRs, and PTCAs
- 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
Hypothesis #2
Specialist driven
Not enough primary care
Primary care as % of MDs

FR: 54%
CH: 48%
CN: 48%
NL: 47%
UK: 45%
DE: 45%
AU: 45%
US: 43%
Mean: 43%
JA: 43%
SE: 33%
DK: 22%
Hypothesis #2 Update

- It’s (surprisingly) not about PC vs. specialty mix
+ OK – so what is it?
Why so much more?
Hypothesis #3
Administrative waste
Governance, administrative spending

<table>
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<th>Country</th>
<th>Percentage of healthcare spending</th>
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<td>FR</td>
<td>1%</td>
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<td>JA</td>
<td>1%</td>
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</tbody>
</table>
Hypothesis #3 Update

- U.S. administrative spending is higher than other countries
- Higher even than countries that have largely private systems
- But that’s only part of the story…..
Total Spending = Quantity \times \text{Price}
Hypothesis #4
Prices of what?
Pharmaceuticals!
Crestor Price

- US: $86
- DE: $41
- Mean: $35
- CN: $32
- JA: $29
- UK: $26
- FR: $20
- AU: $9
Humira Price

- US: $2,505
- DE: $1,749
- Mean: $1,436
- AU: $1,243
- CN: $1,164
- UK: $1,158
- FR: $982
- JA: $980

Humira Price (USD)
Pharma makes up about 15% of all HC spending
So that can’t be the whole story
Generalist Physician Salaries

- US: $218K
- DE: $154K
- CN: $146K
- UK: $134K
- JA: $133K
- FR: $124K
- NL: $111K
- AU: $109K
- AU: $108K
- SE: $86K
Specialist Physician Salaries

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<th>Salary</th>
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<td>$188K</td>
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<td>$182K</td>
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<tr>
<td>DE</td>
<td>$181K</td>
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<td>$171K</td>
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<td>FR</td>
<td>$153K</td>
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<td>DN</td>
<td>$140K</td>
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<tr>
<td>JA</td>
<td>$124K</td>
</tr>
<tr>
<td>SE</td>
<td>$98K</td>
</tr>
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</table>
Nurse Salaries

- US: $74K
- NL: $65K
- AU: $64K
- DN: $58K
- CN: $55K
- DE: $53K
- Mean: $51K
- UK: $49K
- JA: $44K
- FR: $42K
Salaries are complicated
Physician salaries

- Debt
- Length of training
- Opportunity cost in the U.S.
What about other stuff?
Appendectomy

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<th>Country</th>
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<tr>
<td>South Africa</td>
<td>$1,786</td>
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</table>

International Federation of Health Plans 2015
Knee Replacement

- US: $28,184
- Switzerland: $20,132
- New Zealand: $16,508
- Australia: $15,941
- South Africa: $7,795
- Spain: $6,687

International Federation of Health Plans 2015
Bypass Surgery

<table>
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<td>$18,501</td>
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<td>Spain</td>
<td>$14,579</td>
</tr>
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</table>

International Federation of Health Plans 2015
High prices have tradeoffs
Pharmaceutical Innovation

New Chemical Entities

US: 111
CH: 26
JA: 18
UK: 16
DE: 12
FR: 11
Other benefits of higher prices

- High-quality doctors and nurses
- Faster access to diagnostics and procedures
- Nicer amenities and facilities
What about health outcomes?
Life expectancy

Life expectancy, mean, years

<table>
<thead>
<tr>
<th>Country</th>
<th>Deaths per 1,000 live births</th>
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</thead>
<tbody>
<tr>
<td>US</td>
<td>4</td>
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<tr>
<td>CN</td>
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<td>CH</td>
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<td>DK</td>
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<td>UK</td>
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<td>AU</td>
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<td>SE</td>
<td>1.7</td>
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<tr>
<td>JA</td>
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</table>

**Neonatal mortality**
Neonatal mortality given LBW

Deaths per 1,000 live births

<table>
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<tr>
<th>Country</th>
<th>Deaths per 1,000 live births</th>
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<tbody>
<tr>
<td>DK</td>
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<td>NL</td>
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<td>UK</td>
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<tr>
<td>CD</td>
<td>1.63</td>
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<tr>
<td>US</td>
<td>1.61</td>
</tr>
<tr>
<td>DE</td>
<td>1.49</td>
</tr>
</tbody>
</table>
Breast cancer screening

% of women age 50-69

DK  US  NL  UK  SE  CN  DE  Mean  AU  FR  CH  JA

84%  81%  79%  76%  75%  72%  71%  67%  55%  52%  47%  41%
30-day stroke mortality

<table>
<thead>
<tr>
<th>Country</th>
<th>30-day mortality per 1,000 patients</th>
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</thead>
<tbody>
<tr>
<td>CN</td>
<td>10</td>
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<td>SE</td>
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<td>DE</td>
<td>6.4</td>
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<tr>
<td>US</td>
<td>4.2</td>
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</table>
Summary

- High cost healthcare system
  - Driven primarily by administrative costs, prices
- Health outcomes for the population are worse
  - But if you were to get sick, good system to do it
National reforms: ACA and Beyond
Total Spending = \textbf{Quantity} \times \text{Price}
Based on belief that we do too much

- “Value-based” payments for hospitals (VBP, HRRP, etc.) and docs
  - Largely hasn’t done much

- Accountability and changing the “episode” of payment (ACOs, BP)
  - Bit more reason for optimism (savings of 2-4%)
  - Unclear about its scalability/growth
Where is the action going to be?
States!
What does state-based reform look like?

- **Maryland’s All-Payer Model**
  - Hospitals operate on a global budget
  - Hospital revenue for all payers set in the beginning of the year
  - Created target for per capita hospital revenue growth

- **Massachusetts Health Policy Commission**
  - Created target for healthcare spending growth
  - Encourages movement away from FFS model and toward alternative payment models (ACOs, Medicaid APM)
What does state-based reform look like?

- Vermont All-Payer Accountable Care Organization Model Agreement
  - Goal is to attribute 70% of all VT insured residents to an ACO
  - Has set an all-payer growth target and a Medicare growth target

- Arkansas Health Care Payment Reform Improvement Initiative
  - Two strategies:
    - 1) Increase number of patients in patient-centered medical homes
    - 2) Episode-based payments for those with multiple encounters with health system

- Oregon’s Alternative Payment and Advanced Care Model
  - Shift Medicaid reimbursement for Community Health Centers to PMPM
  - Better integrate behavioral health services and increase focus on social determinants
What are states doing?

- 40 states were pursuing value-based payment models in 2019
  - 15 of those states have multi-payer initiatives

- 17 states have adopted or are considering adoption of ACOs

- 12 states have adopted or are considering adoption of episodes of care programs

- CMS’s State Innovation Models initiatives

- Most states participating in the “Money Follows the Person” program for Medicaid patients to reduce nursing facility stays
States tiptoeing into price regulation

- California policy on out-of-network provider charges (max 125% of Medicare)
- RI policy: Hospital rate and ACO budget growth caps (commercial)
  - Considering a cost growth target
- Vermont with an all-payer growth target
- West Virginia has a partial rate-setting system for privately insured patients
- Pennsylvania is piloting an all-payer global budget for rural hospitals
What can we learn from states?

- States are laboratories of innovation
- This is even more true in the era of divided government
- What works for one state may not work for others
- We can create a uniquely American solution
  - States will be leading the way
Thank you!
% Spending on Inpatient Care

<table>
<thead>
<tr>
<th>Country</th>
<th>% Of Health Expenditure Attributable to Inpatient Care</th>
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<td>JA</td>
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% Spending on Outpatient Care

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Physicians per 1,000 population

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State Health Policy in 2019 and Beyond: Making Up for Federal Dysfunction

Len M. Nichols, Ph.D.
American Medical Association State Advocacy Summit
Scottsdale, AZ
January 11, 2019
Overview

• Federal Policy / Election 2020 backdrop

• ACA implementations and transitions
  ➢ Medicaid Expansions
  ➢ Work requirements
  ➢ Other 1115 and DSRIP-esque innovations
  ➢ Marketplace management issues

• Cost Containment: the Old and New Frontier

• Medicare For All, variations and state only versions

• Physician Leadership Opportunities and Challenges
What the Federal Government Will Argue about in 2019-20

• Everything
THE EMPEROR HAS NO CLOTHES!

THE ENEMY OF THE PEOPLE!
HE FOUND THAT HIS ARMS AND LEGS WERE TIGHTLY FASTENED TO THE GROUND.
What the Federal Government Will Argue about in 2019-20

• Everything

• Medicare Drug Price Negotiation

• ACA lawsuits and fixes

• Medicare for All
Status of State Action on the Medicaid Expansion Decision

- Adopted
- Not Adopted

SOURCE: Kaiser Family Foundation, KFF.org
When States Created Their Medicaid Programs

NOTES:
From KFF: A Historical Review of How States Have Responded to the Availability of Federal Funds for Health Coverage, August 2012

Source: diymaps.net (c)
Work Requirements in Medicaid

• 5 states have approval; 11 pending
  ➢ Approved: AR, IN, KY, NH, WI
  ➢ Pending: AL, AZ, KS, ME, MI, MS, OH, OK, SD, UT, VA

• Political appeal is obvious

• Fair assessment depends on details, Evidence mixed so far

• Watch Arkansas and Virginia for where this debate is heading
Section 1115 Medicaid Waivers: Approved and Pending as of December 21, 2018

Use the drop-down menu to sort the map by waiver topic.

Landscape of Approved vs. Pending Section 1115 Medicaid Demonstration Waivers, December 21, 2018

- Approved (46 across 38 states)
- Pending (25 across 23 states)

NOTES: Some states have approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. Pending waiver applications are not included here until they are officially accepted by CMS and posted on Medicaid.gov. For more detailed information on each Section 1115 waiver, download the detailed approved and pending waiver tables posted on the tracker page. "MLTSS" = Managed long-term services and supports.
North Carolina and “Healthy Opportunities”

- Transition from FFS to Managed Care
- Integrate physical and behavioral health plus pharmacy care
- “Whole Person Care” includes upstream services for SDoH/Healthy Opportunities pilot
- => Medicaid MCOs can spend $ on housing, food, transportation, social services
## Social Determinants of Health

### Healthy Opportunities

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<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
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<td>Hunger</td>
<td>Social integration</td>
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<td>Zip code / geography</td>
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</tbody>
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### Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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KFF
Welcome to the AMA Health Workforce Mapper

This tool allows you to visualize the geographic distribution of physicians and non-physician clinicians at a state or county level. Users can also turn on the point locations of providers to see where they are practicing, but this functionality is only available at certain extents to protect the identities of providers. This tool is driven by the American Medical Association's Masterfile data and the Centers for Medicare and Medicaid Services' National Plan and Provider Enumeration System (NPPES). The AMA Masterfile is used for the physicians' locations and the NPPES is used for the non-physician providers' locations.

https://www.ama-assn.org/about/research/health-workforce-mapper
Population Health Mapper
Getting Started: Select an indicator to add to the map. Adjust slider threshold to change map.

Virginia

Social & Economic Factors
Select / Deselect All
- High School Graduation
  - Slider: 58.4 to 75.6
- Some College
  - Slider: 5.3 to 100
- Disconnected Youth
  - Slider: 0 to 82
- Unemployment

Where Do Indicators Overlap?

EXPLORE RELATIONSHIPS
Behavior conditioned by social, economic, and physical context

Source: County Health Rankings
http://www.countyhealthrankings.org/what-is-health
Health is a product of choices – current and past – made subject to constraints, e.g., income, education, insurance, knowledge/expectations of future, physical and social environment (i.e., SDoH or Healthy Opportunities).

Are choices more important than constraints? Philosophers and politicians will always differ.

Odds can be overcome, but, Odds can also be Changed.
And Odds Matter!!

“ZIPCODE” → Life Expectancy

http://www.cohealthmaps.dphe.state.co.us/cdphe_community_health_equity_map/
STRESS PATHWAY from brain to body

Screenshot from Dr. Tony Iton's Tedx Talk
https://www.youtube.com/watch?reload=9&v=0H6yte4RXx0
Health Expenditures as a % of GDP

(Slide borrowed from Lauren A. Taylor)

*Turkey is missing data for 2009; Data from Bradley and Taylor, The American Health Care Paradox.
Total Expenditures as a %GDP

(Slide borrowed from Lauren A. Taylor)

*Turkey is missing data for 2009; Data from Bradley and Taylor, The American Health Care Paradox.*
METHOD: Multivariable regression using state-level repeated measures data from 2000-2009 with regional and time fixed effects.

FINDING: The lagged ratio of social to health spending was significantly associated with better health outcomes: adults who were obese; had asthma; reported fourteen or more mentally unhealthy days or fourteen or more days of activity limitations in the past thirty days and had lower mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes.

(Slide borrowed from Lauren A. Taylor)
Examples from around the country

- Hospital systems (Baylor Scott White (DSRIPs), Intermountain)
- Commercial health plans
- ACA-related: (Re-admission penalties, CHNAs, AHCs, SIM)
- Post-ACA regulatory: Medicaid MCOs and Medicare MA plans, waivers
- Local coalitions (Austin, Waco, DFW, KC, Cleveland, Atlanta, CACHI, Wilmington DE, Cincinnati)
COMMUNITY HEALTH

By Len M. Nichols and Lauren A. Taylor

POLICY INSIGHT

Social Determinants As Public Goods: A New Approach To Financing Key Investments In Healthy Communities

ACA Marketplace Management

- Active purchaser, or not
- Risk pooling rules, outside ACA marketplaces
State run average: $426

Federal run average: $477

Outliers:
- Omaha, NE $821
- Cedar Rapids, IA $724
- Cheyenne, WY $796

Small Group ESI Average: 2017 $535

Figure 2
Average Medical Deductible, in Plans with Combined Medical and Prescription Drug Deductibles (2019)

- Bronze: $6,258
- Silver: $4,375
- Gold: $1,335
- Platinum: $48

SOURCE: Kaiser Family Foundation analysis of Marketplace plans in the 39 states with Federally Facilitated or Partnership exchanges in 2019 (including Arkansas, New Mexico, Oregon, Kentucky and Nevada). Data are from Healthcare.gov. Health plan information for individuals and families available here: https://www.healthcare.gov/health-plan-information-2019/
Figure 4: Average Medical Deductible In Plans with Combined Medical and Prescription Drug Deductible (2019)

- **Silver with no CSR:** Incomes over 250% of FPL (over $30,350 for a single individual) - $4,375
- **Silver, CSR 73% AV:** Incomes 200%-250% of FPL ($24,280-$30,350 for a single individual) - $3,169
- **Silver, CSR 87% AV:** Incomes 150%-200% of FPL ($18,210-$24,280 for a single individual) - $843
- **Silver, CSR 94% AV:** Incomes 100%-150% of FPL ($12,140-$18,210 for a single individual) - $239

Figure 6

Average Out-Of-Pocket Limit In Plans with Combined Limit for Medical and Prescription Drug Cost Sharing (2019)

- Silver with no CSR: Incomes over 250% of FPL (over $30,350 for a single individual)
  $7,374
- Silver, CSR 73% AV: Incomes 200%-250% of FPL ($24,280-$30,350 for a single individual)
  $5,885
- Silver, CSR 87% AV: Incomes 150%-200% of FPL ($18,210-$24,280 for a single individual)
  $2,200
- Silver, CSR 94% AV: Incomes 100%-150% of FPL ($12,140-$18,210 for a single individual)
  $1,073

Insurer Participation in the ACA Marketplaces, By County, 2019

Number of Insurers
- One
- Two
- Three or more

[Map of the United States with color-coded counties indicating the number of insurers per county.]
Insurer Participation on ACA Marketplaces, 2018-2019

Source: Kaiser Family Foundation analysis of data from the 2019 QHP Landscape file released by healthcare.gov on October 24, 2018. Note: For states that do not use healthcare.gov in 2019, insurer participation is estimated based on information gathered from state rate filings. Enrollment is based on 2018 plan selections. 2019 columns may not sum to 100 due to rounding.
<table>
<thead>
<tr>
<th>Legislative or Policy Change</th>
<th>Average percent by which 2019 unsubsidized premiums are higher than would be the case without change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual mandate penalty repeal</td>
<td>6% (all premiums on/off exchange)</td>
</tr>
<tr>
<td>Expansion of AHP / STLD plans</td>
<td></td>
</tr>
<tr>
<td>Loss of CSR payments</td>
<td>10% (silver exchange premiums)*</td>
</tr>
<tr>
<td><strong>Combined Impact:</strong></td>
<td></td>
</tr>
<tr>
<td>Individual mandate penalty repeal</td>
<td>16% (silver exchange premiums)*</td>
</tr>
<tr>
<td>Loss of CSR payments</td>
<td></td>
</tr>
<tr>
<td>Expansion of AHP / STLD plans</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Kaiser Family Foundation analysis of insurer rate filings to state regulators, state insurance regulators, and ratereview.healthcare.gov. Premium impact due to CSR loss is from Congressional Budget Office (CBO) estimate. 

**Notes:** Premium changes represent the change in premiums before accounting for the premium tax credit. How each premium impact relates to other impacts depends on how each insurer calculates rate impacts. We conservatively assume the rates are additive (6% + 10% = 16%), as opposed to multiplicative (1.06 x 1.1 = 1.166, or 16.6%). *The CBO estimate of the loss of CSR payments' effect was specifically for silver exchange premiums. However, some insurers also applied a CSR load onto other metal levels and/or off-exchange premiums.
Which Policies Came First: Cost Reduction, Access Expansion, or Quality Improvement?

- First health policies in US?
  - Virginia (1639), Mass (1649), NJ and NY (1665) regulated physician FEES
  - 1760 NYC banned unlicensed medical practice
  - By 1830, all but PA, NC, and VA had licensing boards
Our Major Problem: Family Premium / Family Income

<table>
<thead>
<tr>
<th>Year</th>
<th>Family Premium / Family Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>7.4%</td>
</tr>
<tr>
<td>2016</td>
<td>23.4%</td>
</tr>
</tbody>
</table>
Exhibit 7. Year-over-Year Percentage Change in Spending and GDP

Source: Altarum monthly national health spending estimates. Monthly GDP is from Macroeconomic Advisers and Altarum estimates.
Note: Lightly shaded bars denote recession periods.
Individual CMMI payment models’ performance mixed → disappointing, glass <½ full?

• ACOs
 ➢ MSSP → Saving Medicare some money,* MD led are best**
 ➢ Pioneer → Most left the program (8 at end)
 ➢ Next Generation? n=51, Saved about 1% in 2016

• Primary Care
 ➢ CPCI → CPC+* No net savings, very little Q move

• Bundled Payments (Models 2* {acute and post-acute} and 4** {prospective acute}) → Only savings were in post-acute

**McWilliams et al, NEJM 9/5/2018
State Options for Health Care Cost Control

- Medicaid Reforms
  - DSRIP, MLTSS, MCO flexibility → SDOH, ACH-like
- Transparency related
  - APCD-based
- Drug Price Efforts
- Global budget targets (Massachusetts)
DATAWATCH

Low-Cost, High-Volume Health Services Contribute The Most To Unnecessary Health Spending

An analysis of data for 2014 about forty-four low-value health services in the Virginia All Payer Claims Database revealed more than $586 million in unnecessary costs. Among these low-value services, those that were low and very low cost ($538 or less per service) were delivered far more frequently than services that were high and very high cost ($539 or more). The combined costs of the former group were nearly twice those of the latter (65 percent versus 35 percent).

EXHIBIT 2

The 10 most costly low-value services in Virginia, 2014

<table>
<thead>
<tr>
<th>Low-value service</th>
<th>Mean cost per service*</th>
<th>Total unnecessary costs (millions)*</th>
<th>Total services measured</th>
<th>Services deemed low value</th>
<th>Ranking by use</th>
<th>Waste index*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline lab tests for low-risk patients having low-risk surgery</td>
<td>$487</td>
<td>$227.8</td>
<td>595,552</td>
<td>467,884</td>
<td>1</td>
<td>78.6%</td>
</tr>
<tr>
<td>Stress cardiac or other cardiac imaging in low-risk, asymptomatic patients</td>
<td>$3,404</td>
<td>$93.2</td>
<td>244,87</td>
<td>27,385</td>
<td>13</td>
<td>11.2%</td>
</tr>
<tr>
<td>Annual EKGs or other cardiac screening for low-risk, asymptomatic patients</td>
<td>$298</td>
<td>$41.0</td>
<td>2,823,557</td>
<td>137,666</td>
<td>5</td>
<td>4.9%</td>
</tr>
<tr>
<td>Routine head CT scans for ED visits for severe dizziness</td>
<td>$1,569</td>
<td>$24.6</td>
<td>29,816</td>
<td>15,724</td>
<td>15</td>
<td>52.7%</td>
</tr>
<tr>
<td>EKGs, chest X-rays, or pulmonary function tests in low-risk patients having low-risk surgery</td>
<td>$964</td>
<td>$21.3</td>
<td>33,754</td>
<td>32,900</td>
<td>11</td>
<td>97.5%</td>
</tr>
<tr>
<td>Population-based screening for vitamin D deficiency</td>
<td>$125</td>
<td>$20.6</td>
<td>165,034</td>
<td>165,031</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>PSA-based screening for prostate cancer in all men, regardless of age</td>
<td>$144</td>
<td>$18.9</td>
<td>341,554</td>
<td>131,419</td>
<td>6</td>
<td>38.5%</td>
</tr>
<tr>
<td>Routine imaging for uncomplicated acute rhinosinusitis</td>
<td>$2,365</td>
<td>$17.1</td>
<td>14,196</td>
<td>7,220</td>
<td>19</td>
<td>59.0%</td>
</tr>
<tr>
<td>Routine annual cervical cancer screening in women ages 21–65</td>
<td>$91</td>
<td>$15.3</td>
<td>220,241</td>
<td>167,252</td>
<td>3</td>
<td>75.9%</td>
</tr>
<tr>
<td>Imaging for low-back pain within the first six weeks of symptom onset, in absence of red flags</td>
<td>$330</td>
<td>$13.9</td>
<td>48,857</td>
<td>42,110</td>
<td>9</td>
<td>86.2%</td>
</tr>
</tbody>
</table>

SOURCE: Authors’ analysis of data for 2014 from the Virginia All Payer Claims Database. NOTES: “Low-value services” are defined in the Notes to Exhibit 1. EKG is electrocardiogram. CT is computed tomography scan. ED is emergency department. PSA is prostate specific antigen. *Average (mean) amount of money per service paid to a health care provider across all payers (including patients’ out-of-pocket spending). †Mean cost per service multiplied by total number of low-value services. ‡Number of low-value services divided by the total number of services measured.
State Drug Pricing Policy
Actions and Options

• Ballot Initiatives (limit states’ prices to VA prices)
• Transparency laws
  ➢ From justify increases to Drug Cost Commission
• Reimportation initiatives
  ➢ NCSL worked out legal architecture, VT is live in 2019
• Medicaid formulary flexibility
Medicare for All/
Single Payer at State Level

- Vermont came the closest, has backed off for now
- Public option/buy-ins for Medicaid (NV passed, but vetoed)
- Medicare buy-in is the least aggressive form of Medicare for All
- Medicare for All has many flavors:
  - Medicare FFS for All
  - Medicare “as is” for All
  - Enhanced Medicare for All
  - Medicare Advantage for All
So What Have We Learned?

• Health care STILL costs too much
• Reducing Cost Growth is Complicated
  ➢ Cost-shifting and zero-sum solutions don’t work long term
• We haven’t settled main debate: role of Government
• We NEED leadership at all levels
• How Might Physicians Lead?
  ➢ Focus on state and local levels for a while
  ➢ Help make health care & policy non-partisan
  ➢ Help reduce generalized fear, by building on main asset:
    ❖ Doctor-Patient relationship
What Do We Need?

- People who can help us be honest with each other again
  - We are all better off if the whole population is healthier
  - We pay for the uninsured anyway, why not do it smarter?
  - People were hurt by ACA. Why not help them without hurting those who gained?
  - Cost growth reduction requires stakeholders’ willing collaboration
  - Drug pricing rules are not in the Constitution, or the Bible

- People who can remind us to respect each other again
  - Plenty of blame to go around. Collaborative solutions are also there to be found, if we can overcome our failures of imagination. (LoveLoud!)
OPIOIDS AND CORRECTION SETTINGS

Elizabeth Salisbury-Afshar, MD, MPH
Director, Center for Multi-System Solutions to the Opioid Epidemic
Medical approaches to opioid crisis

• Safer opioid prescribing and disposal
  – Prescription drug monitoring programs
  – Drug take-back initiatives
  – Provider education (and education mandates)
  – Regulation and legal action regarding “pill mills”
  – Opioid prescribing limits (insurance and legislation)

• Screening, brief intervention, and referral to treatment

• Increasing access to opioid use disorder (OUD) treatment

• Overdose response education and naloxone prescribing
Why focus on treatment in correctional settings?

- Criminal justice exposure is common for people who use opioid
  - Each year, **1 in 3 people** with opioid use disorder are arrested

- People leaving incarceration are at up to **8 times increased risk** of overdoes death in the first two weeks after leaving incarceration

- Offering methadone or buprenorphine treatment for individuals with opioid use disorder who are incarcerated **reduces death and improves outcomes**

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Using Science to Inform Policy and Practice

- New York City Rikers Island jail
- Rhode Island (unified prison and jail system) started offering medications for addiction treatment in July 2017
- Vermont recently passed legislation to support integration of the use of medications for opioid use disorder treatment
Substance Use Disorders 101:

1. Substance use disorders are CHRONIC conditions
   - Genetic, environmental, behavioral influences, trauma/adverse childhood experiences

2. Substance use disorders are not simply about substance use, but rather the behaviors that develop around the use of substances
   - Compulsions, Cravings, Continued use in spite of negative consequences

3. Treatment works, but not all treatment has equivalent outcomes
   - For OUD, the use of medications for addiction treatment have best outcomes
   - Buprenorphine and methadone have been shown to reduce mortality by as much as 50%
Advocating for Change:

• Addiction is a chronic condition; we need to advocate that it is treated like other chronic conditions

• Ensuring access to evidence-based treatment for people in correctional settings is a critical component of the response to the opioid epidemic
  – Not offering evidence based treatment for people who are incarcerated increases risk of death

Panelists

• Ricky Bluthenthal, PhD
  – Professor and Dean of Social Justice, Keck School of Medicine

• Jessie Rossman, JD
  – Staff Attorney, ACLU Massachusetts

• Annie Ramniceaunu, CLMHC, LADC
  – Addiction and Mental Health Systems Director, Vermont Department of Corrections
NEED FOR AND EFFECTIVENESS OF MEDICATION TREATMENT IN CORRECTIONAL SETTINGS FOR PEOPLE WITH OPIOID & HEROIN USE DISORDER

- Ricky Bluthenthal
- Associate Dean for Social Justice
- Professor
- Department of Preventive Medicine
- Keck School of Medicine
- University of Southern California
Overview

- Unmet need for opioid and heroin related treatment
- Prison and jails as evidenced-based locations for treatment and care
- Evidence of effectiveness of prison/jail OUD treatment
First principles

Any use of medication treatments is better than use of illegally produced/distributed drugs.

Making treatment more available and less expensive than illegally produced/distributed drugs should be our goal.

Making treatment difficult to receive achieves has no therapeutic value.

Stigmatization of drug users makes health problems worse and interferes with implementation of effective prevention and treatments.
Opioid and Heroin Use Disorder consistent of

• Compulsive use in spite of consequences

• Withdrawal syndrome when use stops

• Withdrawal symptoms peak around day 3 or 4 but can persist for weeks and months

• In my studies of people who inject heroin, 85% report having withdrawal symptoms in the last 6 months, average of 46 episodes per 6 months, and 57% regard these symptoms as severely painful.*

Unmet need for treatment

In 2017, an estimated 2.1 million people had opioid use disorder in the US.

Roughly, 20% to 30% of people who had opioid use disorder received any kind of treatment in the last year.
To Battle The Opioid Overdose Epidemic, Deploy The ‘Cascade of Care’ Model, "Health Affairs Blog, March 13, 2017. DOI: 10.1377/hblog20170313.059163

Opioid use disorder cascade
Treatment capacity is inadequate and the majority do not provide medication treatment
Risk associated with not providing treatment while incarcerated
Post-released mortality is elevated

Meta-analysis confirms elevated mortality for opioid users

Evidence for medication treatment for people with opioid use disorder in prison and jail
Medication treatment during incarceration reduces drug related mortality after release


![Figure 2](image-url)  
*Figure 2*  Survival curve during the year following release (drug-related poisoning mortality). OST = opioid substitution treatment.
Treatment while incarcerated improves treatment engagement following release


**Figure 3** Time to admission to community drug misuse treatment in first 4 weeks after prison discharge by opioid substitution treatment (OST) prison exposure: Kaplan–Meier plot.
In Rhode Island, receiving methadone prior to release associated with less heroin use, less drug injection, and fewer non-fatal overdose episodes.
Providing medication treatment through prison/jails can be done

Giftos, J. “Operational feasibility of MAT in the criminal justice system.” Correctional Health Services, New York, New York. https://drive.google.com/file/d/0Byheg1-QKHfANVNyU3hsVjLVVi0wRF9wZ3Rwem5Nc1JsTE1z/view
Next steps

Make medication treatment available in existing opioid treatment programs

Get trained to provide buprenorphine

Work to remove pre-authorizations for providing OUD treatments

Patients need access to variety of treatment medications – methadone, buprenorphine, naltrexone (vivitrol)

Patients need access to different formulations, doses, routes of administration (oral, sublingual, injectable), and durations of effect (hours to months)
Conclusion

Medication treatment is the community standard of care and should be available in all appropriate settings.

Medication treatment is feasible.

Medication treatment is life-saving for people with opioid use disorder who have been incarcerated.
Medication Assisted Treatment in Vermont Correctional Facilities

Annie Ramniceanu, LCMHC, LADC
Director of Addiction and Mental Health Systems
Vermont Department of Corrections
Annie.ramniceanu@Vermont.gov
Goals

1. Provide a brief overview of Medication Assisted Treatment in Vermont
2. Provide a brief summary of Act 176.
3. Provide overview of VT DOC & statewide MAT program
4. Provide brief Summary of lessons learned:
History of Medication Assisted Treatment in Corrections

• Act 76 (2013): Demonstration Project
  • Pilot in 2 facilities. M/F
  • MAT Continuation for up to 90 days
    • Goals: increase access; improve health outcomes; ensure parity; and identify sustainable systems for MAT delivery in correctional setting

• Act 195 (2014)
  • Establish an MAT workgroup which would conduct the research needed to further expand the program and develop evaluation of Act 76 Demonstration Project
  • Also included implementation of Naloxone/Narcan for all pilot participants

• Report and Recommendations delivered to committees of Jurisdiction on 11/2016 (Legislative session 2017):
  • Increase dosing schedule up to 120 days based on medical necessity on a case by case basis across all facilities
  • MAT workgroup to update all protocols and procedures to support the roll out of the expansion
  • Create a Clinical Sub group to support principal MAT work group partners
2018 Vermont Legislative Session:

ACT 176

Effective date 7.1.2018

Created a legal definition for Medication Assisted Treatment for the Vermont populace in VSA Title 18:

“the use of US Federal Drug administration approved medications in combination with counseling and behavioral therapies to provide a whole person approach to the treatment of substance use disorders.” Substance Abuse Mental Health Services Administration (SAMHSA)

Created legislative intent for Correctional population in VSA Title 28:

“It is the intent of the General Assembly that MAT offered at or facilitated by a correctional facility is a medically necessary component of treatment for inmates diagnosed with opioid use disorder.”

and that MAT in corrections shall have the same meaning as in Title 18.
Act 176
Directed VDOC to:

- Continue all inmates with verified prescription
- At any time during incarceration, provide OUD screening/assessment and determine medical necessity for MAT
- If Buprenorphine specific MAT is not clinically indicated and assessment for Methadone is...then facilitate access to methadone induction and maintenance
- Induct all patients, if medically necessary, pre-release as part of release planning
- Provide care coordination at release: VT Hub & Spoke Provider System
- Behavioral Component is required if medically necessary
- Evaluate effectiveness by 2022
VDOC & Medication Assisted Treatment Program administered through contracted Health Services

6 facilities across state:
Average daily Population +/- 1750

Bed capacity 115 - 366

Integrated System: Detainees, sentenced; jail < 1 year; and Prison > 1 year and Federal

Male: 1380; Female: 163; Detainees: 376; Feds: 62; Out of state: 220
VDOC MAT by the numbers since July 1, 2018

1000 +/- unique patients have been provided MAT

Over half have been deemed medically necessary through VDOC screening/assessment process

The other half have been continued via verified prescriptions at intake

As of 1.6.18 unique patients:

- 528 on “MAT” medications
- 454 on Subutex
- 55 on Methadone
- 19 on Naltrexone
Behavioral Component: Therapy and Recovery Supports

- Voluntary until medically necessary
- Medical necessity (at present) is triggered when a patient is aggressive
- Individual counseling via sick slip
- Integrated Change Therapy: 16 session Group Tx: Cognitive Behavioral Therapy (CBT) and Motivational Enhancement Therapy (MET).
- Forensic Peer Recovery Coaches: Open Ears Program: Largest facility: +/- 150 contacts/week
- VT Recovery Network Centers partnership: NA/AA, MAR and SMART Recovery groups
Lessons Learned and Still Learning

- Leadership at every level: Dedication to the mission
- Managing culture change and stigma
- Right staff in right place
- Dosing and staffing
- Policies and Procedures/ Plan Do Study Act (PDSA) change cycles evolve and devolve rapidly: Disruptive Innovation....It is MESSY!
- Dedicated clinical workgroup and consultation
- Projected need/demand
- Managing release and spontaneous releases from court
- Care Coordination
- Connecting to and developing post release capacity
- Data Collection and Evaluation Process versus Implementation CQI

• $$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$$
Gratitude

• VT estimates that there are over 20,000 citizens suffering with OUD
  • Only 8,000 are accessing treatment via VT Hub & Spoke Community system
• VT estimates that there are +/-7,000 unique individuals coming in and out Correctional facilities annually
  • Currently only 50% are continued on community based verified Rx
• While we certainly do not want people to be incarcerated in order to get treatment, providing MAT in Corrections as the numbers show...will increase access to treatment.

It is an honor and a privilege to impact so many lives by bringing compassionate, holistic and evidence based treatment to so many people
Steps to Improve Competition
1. Preserve and Protect the ACA

- Limit Short-Term Insurance Plans
- Limit availability of Association Health Plans
- Preserve Cost Sharing Subsidies
- Establish a State Individual Mandate
- Support Medicaid Expansion nationwide
- Support litigation efforts to protect the ACA
2. Payment Reforms

• Support site neutral payment reforms
• Adjust MACRA (MIPS) to reduce burdens & lessen incentives to accept hospital employment
• Support regulations to reduce state law and reimbursement barriers to telehealth
• Adjust CMS ACO regulations to support entry by physician-led groups and prevent “ACO squatting”
• Reform 340B program to reduce artificial incentives for physician/hospital consolidation
• Laws mandating unbundled pricing of hospital services
3. Remove Regulatory Barriers to Entry

- Eliminate or modify Certificate of Need Laws
- Eliminate or modify Any Willing Provider Laws
- Eliminate Certificate of Public Advantage Laws
- Eliminate the Corporate Practice of Medicine bar
- Reexamine and update scope of practice and licensure rules for complementary and alternative medicine
- Reducing paperwork burdens by developing standardized consensus quality reporting measures
- Exercise care in regulating (e.g. narrow network laws and nurse/staff ratios)
4. Curtail Private Anticompetitive Practices

• Eliminate anticompetitive provisions in insurance and hospital contracts
  • Anti-steering/anti-tiering clauses
  • Most-favored-nations clauses
  • “Gag” clauses

• Require accurate and updated provider network directories

• Prohibit “all or nothing” contracting by hospital systems

• Vigorous antitrust enforcement vs. predatory and collusive conduct & anticompetitive mergers.
5. Regulatory Interventions

- Price Transparency laws
- Create State *All-Payer Claims Databases*
  - Department of Labor regulations governing self-insured plans
- PBM Reform: Pass through pricing
- Enable physician-sponsored hospitals
- Insurance Rate Reviews
  - Rate Setting and Transparency
  - Rate caps and corridors for dominant providers
- All Payer Rate-Setting and Global Budgets
PBM Economics

Neeraj Sood, PhD

Vice Dean for Research and Professor,
USC Price School of Public Policy & USC Schaeffer Center
PBM Economics

• What is the role of PBMs in the pharmaceutical supply chain?
• How well is the PBM market functioning?
• Potential policy solutions
Flow of prescription drugs

PBMbs are true middle men, they play no role in the physical distribution of prescription drugs to consumers.
Flow of services

- Manufacturer
  - R&D, marketing, manufacturing

- Wholesaler
  - Wholesale distribution

- Pharmacy
  - Retail distribution

- PBM
  - Manage drug benefits

- Health Plan
  - Rx drug coverage

- Plan sponsor
  - Employer

- Beneficiary
PBM relationship with other supply chain participants

Manufacturer

Distributor

Pharmacy

Beneficiary

PBM

Provide market access

Receive rebates & adm. fees

Health Plan

Provide market access

Pay pharmacies on behalf of health plans

Manage drug benefit

Employer
How do PBMs make money?

- **Manufacturer**
  - Provide market access
  - Receive rebates & adm. fees

- **Distributor**
  - Pay pharmacies on behalf of health plans

- **Pharmacy**
  - Pay pharmacies on behalf of health plans
  - Pass through some rebates to health plans

- **Health Plan**
  - Pay pharmacies on behalf of health plans
  - Retained Rebate: Difference between rebate received from the manufacturer and amount passed through to plans
  - Spread Pricing: Difference between negotiated payment from health plan and what is paid to pharmacies

- **Beneficiary**
  - Receive negotiated payment for reimbursing pharmacies & admin fee

- **Employer**
  - Provide market access
  - Manage drug benefit
PBM Economics

- What is the role of PBMs in the pharmaceutical supply chain
- How well is the PBM market functioning?
- Potential policy solutions
Buying a house:

- Sally is considering buying a house.
- Her real estate agent is John.
- John negotiates with the seller a $10,000 reduction in the price of the house.
- Sally pays $10,000 less for the house.

Scenario:

- She now has two agents: John & Joe
- John negotiates a $10,000 discount from the seller. The amount is secret and not disclosed. He keeps some of the money and passes the rest to Joe.
- Joe keeps some of the undisclosed money received from John and passes the rest to Sally.
- How much of the $10,000 did Sally receive?
Lack of transparency means consumers might not benefit from higher rebates

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# Rebates misalign incentives: Not choosing cheaper drugs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Retail Price</th>
<th>rebate</th>
<th>PBM keeps</th>
<th>Cost to health plans</th>
<th>Cost to consumers?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug A</strong></td>
<td>$200</td>
<td>$50</td>
<td>$5 ✔</td>
<td>$155</td>
<td>✔ Uninsured might pay list price</td>
</tr>
<tr>
<td><strong>Drug B</strong></td>
<td>$100</td>
<td>$30</td>
<td>$3</td>
<td>$73 ✔</td>
<td>✔ Insured consumers below deductible might pay list price ✔ Insured may pay higher premiums</td>
</tr>
</tbody>
</table>

*Assume retail and wholesale mark-up is 10%; PBM keeps 10% of rebate*
Lack of competition in the supply chain

- Highly concentrated supply chain with few key players controlling large market shares
  - Top 3 PBMs account for roughly 75% of covered lives
  - Wholesale, pharmacy and insurer markets are also highly concentrated
  - Of $100 spent on drugs, $42 goes to PBMs, wholesalers, pharmacies, and insurers.
Consolidated PBM markets means higher costs for consumers

- Dominant PBMs might negotiate higher rebates but not pass rebates to health plans
- Dominant PBMs might engage in excessive “spread pricing”
New wave of vertical consolidation in pharma supply chain might further curtail competition

• Misaligned incentives
  – A PBM that owns a pharmacy might favor its own pharmacy even if rival pharmacies have lower costs
  – A PBM that owns a health plan might try to increase drug costs of rival health plans

• Barriers to entry
  – Need to entry several distinct supply chain markets to effectively compete in the market
PBM Economics

- What is the role of PBMs in the pharmaceutical supply chain
- How well is the PBM market functioning?
- Potential policy solutions
Recommendation one: Improve drug price transparency throughout the supply chain

• Improve drug price transparency throughout the supply chain by following the flow of money for “tracer” drugs.

• Tracer drugs are:
  – Those that account for significant fraction of state/federal spending on drugs
  – Those that have experienced significant increase in list price

• Any firm (manufacturer, wholesaler, PBM, pharmacy etc) that does not participate cannot get state/federal funding
Recommendation two: Move from a rebate system to a discounts model

- Discount model ensures that price reductions are passed to health plans and consumers
- Discount model better aligns incentives of PBMs with incentives of payers and consumers
Recommendation three:
Mandate pass-through of rebate to consumers

- Ensures that consumers get the benefits of rebates
- More equitable as sick consumers using drugs are not subsidizing healthy consumers not using drugs
Recommendation four:
Outlaw unfair business practices of PBMs

- Limits to spread pricing
- Minimum rebate pass through
- Limits to favorable pricing for affiliated business units such as health plans and pharmacies
Recommendation five: 
Reduce barriers to entry in the PBM market

• I do not know how to do this, but it is a good idea!
AMA State Advocacy Summit

*Early Communication and Resolution: A Patient-focused Approach to Medical Liability Reform*

Alan C. Woodward, MD, Founder, Massachusetts Alliance for Communication and Resolution Following Medical Injury
Cheryl M. DeKleine, Esq., Senior Director, Claims Management & Litigation Counsel, Ascension Care Management
Leilani Schweitzer, PEARL Patient Liaison, The Risk Authority, Stanford University Healthcare

Moderator: Brian K. Atchinson, President and CEO, Medical Professional Liability Association
• What are they?
• Why are they important?
National in Scope — Federal Activities

• U.S. Department of Health and Human Services
  • Agency for Healthcare Quality & Research
    • Communication AND Optimal Resolution Program (CANDOR)

• Proposed Legislation
  • Accessible Care by Curbing Excessive lawSuitS (ACCESS) Act of 2017
    • Apology protections
    • Advance notification periods before suits may be filed
State Laws

- 3 states have formal early disclosure laws in place
- 39 States have apology protections in place
  - 34 states have laws applying to acts of benevolence related to an injury
  - 5 states have laws applying to broadly defined “accidents”
- 27 States require disclosure/reporting of unanticipated outcomes
  - 10 states require disclosure of unanticipated outcomes to patients
  - 11 states require reporting of never events
  - 16 states require reporting of “serious adverse events”
Additional Activities

• The Joint Commission
  • Disclosure
  • Sentinel Event Reporting

• Collaborative for Accountability and Improvement
  • University of Washington School of Medicine
Delivery of Care Models in U.S. Hospitals/Health Systems

• All clinicians are employed and insured by H/HS
• Some clinicians are employed and/or insured by H/HS
• Few or no clinicians are employed or insured by H/HS
Communication, Apology, and Resolution (CARRe):

Alan Woodward, MD
Past President of the Massachusetts Medical Society and Founder of MACRMI
What is Communication, Apology, and Resolution (CARe)?

- **Communicate** with patients and families when unanticipated adverse outcomes occur, and provide for their immediate needs.
- **Investigate and explain** what happened.
- Implement systems to **avoid recurrences** of incidents and improve patient safety.
- Where appropriate, **apologize** and work towards **resolution** including an offer of fair compensation without the patient having to file a lawsuit.
Transformational Change

- Reactive \(\rightarrow\) Proactive
- Adversarial \(\rightarrow\) Advocacy
- Culture of secrecy \(\rightarrow\) Full disclosure / transparency
- Denial \(\rightarrow\) Apology (healing)
- Individual blame \(\rightarrow\) System improvement
- Patient/MD isolation \(\rightarrow\) Supportive assistance
- Fear \(\rightarrow\) Trust
- Defensive medicine \(\rightarrow\) Evidence-based medicine
DAO/CARe History through 2012

- VA Hospital: 1990s
- MMS Engagement: 2005
- Legislation MACRMI Implementation: 2012
  - 2001: University of Michigan
  - 2010: AHRQ Planning Grant / Roadmap
AHRQ Planning Grant

- 1 Yr - 300K AHRQ Planning Grant - MMS / BIDMC
- Key informant interview study of 27 knowledgeable individuals from all leading stakeholder constituencies in Massachusetts
- Twelve significant barriers were identified along with multiple strategies to overcome each one
- Strategies for each barrier were then evaluated and prioritized to develop our Roadmap
- CARe is the best of all options for liability reform, the right thing to do and broad support exists for change
Roadmap: Overcoming Barriers

- Enabling Legislation - to create a supportive environment for broad adoption
- Leadership - from all key constituencies
- Best Practices - support consistency
- Collaborative Working Groups - key issues
- Education - programs for all involved parties
- Data Collection and Dissemination
Liability Reform Provisions Ch. 224

- Six Month Pre-Litigation Resolution Period*
- Sharing all Pertinent Medical Records*
- Apology Protection - unless contradictory*
- Full Disclosure - significant complication*
- Pre-judgment Interest Reduction - T+2
- Charitable Immunity Cap Increase - 100k

Signed into law as part of Chapter 224 - Payment Reform Legislation; Effective November 5, 2012

* MMS, MATA & MBA Consensus
“CARe” (Communication, Apology, and Resolution) is MACRMI’s preferred way to reference the process.
MACRMI Efforts

- Secured local funding
- Established Pilot Programs
- Launched Website
- Clarified reporting requirements
- Developed comprehensive resources
- Collected and Analyzed Data
- Hosted Annual Forums
MACRMI is a Massachusetts alliance of patient advocacy groups, teaching hospitals and their insurers, and statewide provider organizations committed to transparent communication, sincere apologies and fair compensation in cases of avoidable medical harm. We call this approach Communication, Apology, and Resolution (CARe) and we believe it is the right thing to do. It supports learning and improvement and leads to greater patient safety.

This site is a central resource for information on the CARe approach and the health care institutions implementing it. Here you will find answers to many of your questions regarding medical injury, resources and support for patients, families and clinicians, education and training resources for health care providers, sample guidelines and policies, research and articles, and ways to connect with each other. By sharing what we learn from medical errors and near misses, we are enhancing patient safety together and improving our health care system. Thank you for participating.
MACRMI Resources

- Site Readiness Checklist
- Sample CARe policies / procedures and FAQs for Patients, Providers and Attorneys
- CARe Algorithms and Timeline
- Patient Brochure and Information Sheet
- Slide decks for teaching the concepts to clinicians - ID Badge instructions
- CARe Best Practices for institutions, patient interaction and patient representation, attorneys, and insurers
- A Detailed Implementation Guideline
Cases tracked in MA study

Screened in: 991

- Referred to insurer: 160 (16%)
  - 99 closed (61.9%)

- Not referred to insurer: 821 (83%)
  - 817 closed (99.5%)

- Insurer status not yet determined: 10 (1%)
  - All pending

Findings

- Most of the work of CARe is communicating about non-error events
- No avalanche of new claims – actually fewer at 3 of the 4 pilot sites
- Defense costs reduced at both academic medical centers, and no cost increases
- Compensation costs were modest with a median payment of $75K
Pilot Study Conclusions

- Hospitals can rigorously implement CRPs without increasing their liability exposure.
- Some cost savings are realized shortly after implementation and savings should increase as safety measures are implemented.
- We hope the CRP discussion will move away from liability concerns and cost to how best to implement programs and improve patient safety.
Providers are supportive of CARe

Overall, how supportive are you of using the CARe process to resolve unanticipated outcomes? (n=108)

* 74 respondents said they did not know enough to answer this question.
Patient Experience Study

- First major study of patient / family perceptions of CARe-type programs primarily at BI, Baystate and Stanford

- Examples of identified themes
  - Ask, rather than assume, what the patient wants
  - Recognize emotional aspects; need to “tell the story”
  - Recognize value of lawyers (neutrality, objectivity)
  - Importance in communicating patient safety results
  - Value of interim payments

- Revamped policies, algorithms, and Best Practices to address these issues

https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2656885
Implementation Lessons Learned

- Culture - organizational commitment
- Leadership - champions MDs and Execs
- Consistency and Rigor in all cases
- Teamwork - Patient Relations / Risk Management / Insurer
- Support for clinicians and patients
- Education and Reinforcement
MACRMI’s Journey

2012

AHRQ Planning Grant

Gather Stakeholders together

Pilot CARe program to gather evidence

Recruit additional CARe sites

Develop website & free resources to lower barriers to entry

HA Articles Published

Broad dissemination to change the culture in MA and beyond

Today
Conclusion

- CARe is the right thing to do for
  - Patients
  - Providers
  - Healthcare institutions / ACO
  - Our healthcare system

- In 2017 the AMA adopted Policy H-435.941 supporting CARe-type programs as a “viable option to settle disputes…”
Why Core?

A sustained proven model for talking openly with patients and families about unanticipated adverse outcomes

Lessen the emotional distress on patients, families and caregivers associated with adverse events by providing skills and pathways to follow

Reduce the likelihood of contentious and expensive litigation by attempting to reach an equitable resolution when financial compensation is appropriate
Team Approach for Unreasonable Care

- Disclosure conversation occurs with the patient and/or family
- An apology for care that led to harm
- Debrief- offer emotional support for all involved (2 & 3 victims)
- Post disclosure ACM Claims teams evaluates if the harm has a financial component – fair to all
When does a case need to be resolved?

When the care is “reasonable”, a conversation with some explanation is usually all that is needed to resolve the issue.

When a case is one of CLEAR liability, it should be resolved as expeditiously as possible using the CORE® TEAM approach.
Impact of CORE®

CORE® contributes to significant reductions in lawsuits

Loss date 5 Years before and after 7/1/2010. Includes all open, reopened, and closed suits. HPL and PPL only.

Basket 1
- Pre-CORE®: 20
- Post-CORE®: 7

Basket 2 & 3
- Pre-CORE®: 34
- Post-CORE®: 27
Do the Right Thing Because it is the Right Thing to Do

Patient Bill of Rights: list of guarantees that set the foundation for open, honest communication

The patient has the right to receive considerate, respectful care and to be treated with dignity and receive COMPLETE information about diagnosis, treatment and prognosis

Dignity: Quality of being worthy
Respect: High or special regard
Compassion: Sympathetic consciousness of others’ distress together with desire to alleviate it

Dignity + Respect + Compassion = TRUTH
PEARL:
A Hybrid Values & Claims Centric Model
PEARL is based on the fundamentals of communication, transparency & integrity.
Disclosure Intentions into Disclosure Practice
PEARL Map
No Longer Practicing Medicine
Two Questions:
What would happen at your hospital if a child died because of an error?
What would you want to happen if that child was yours?
Unintended Errors vs. Deliberate Choices
Questions?