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Health Policy Meets Medical Ethics:

Physician Role in the Emerging Health Care System

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Disclosures

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- Dr. Brennan receives salary, stock and stock options from CVS Caremark, a company that distributes pharmaceuticals on a retail and mail order basis, and manages pharmacy benefit for health plans and employers to lower costs and improve quality
- Views represent those of the Dr. Brennan, not CVS Caremark

Outline of Discussion

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- Demographic and Economic Forces are Pushing the United States Health Care System inevitably to a New Model
- In the New Model, physicians and other providers will have much more important roles in the distribution of health care services
- Medical Ethics has Adapted to this Reality, but Will Need to Continue to Evolve

Stronger Pressure to Reduce Costs: Aging Population

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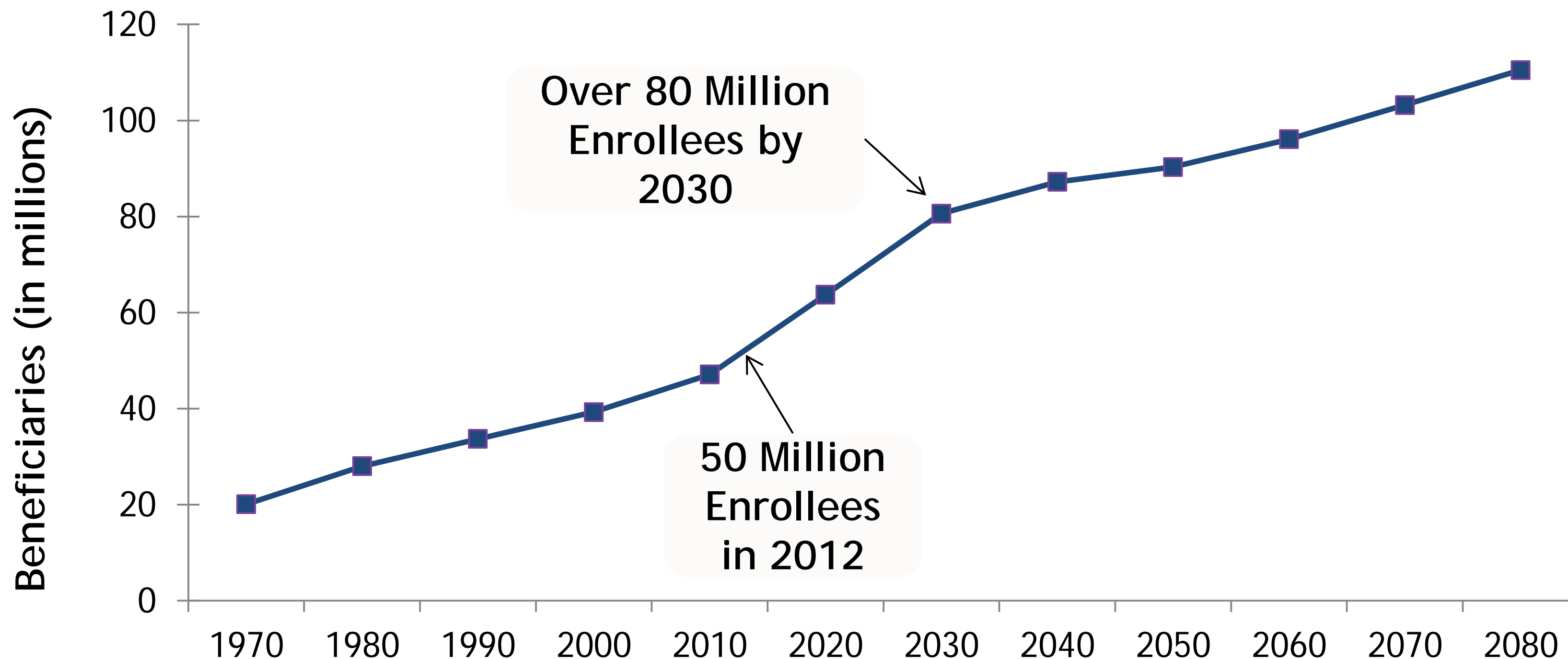

Between 2011 and 2030, Baby Boomers will turn 65 at a rate of 10,000 per day[2]

[1] Centers for Medicare & Medicaid Services Office of the Actuary, 2012.
[2] Pew Research Center, December 2010.

Stronger Pressure to Reduce Costs: Health Care Crowds out Other Social Programs

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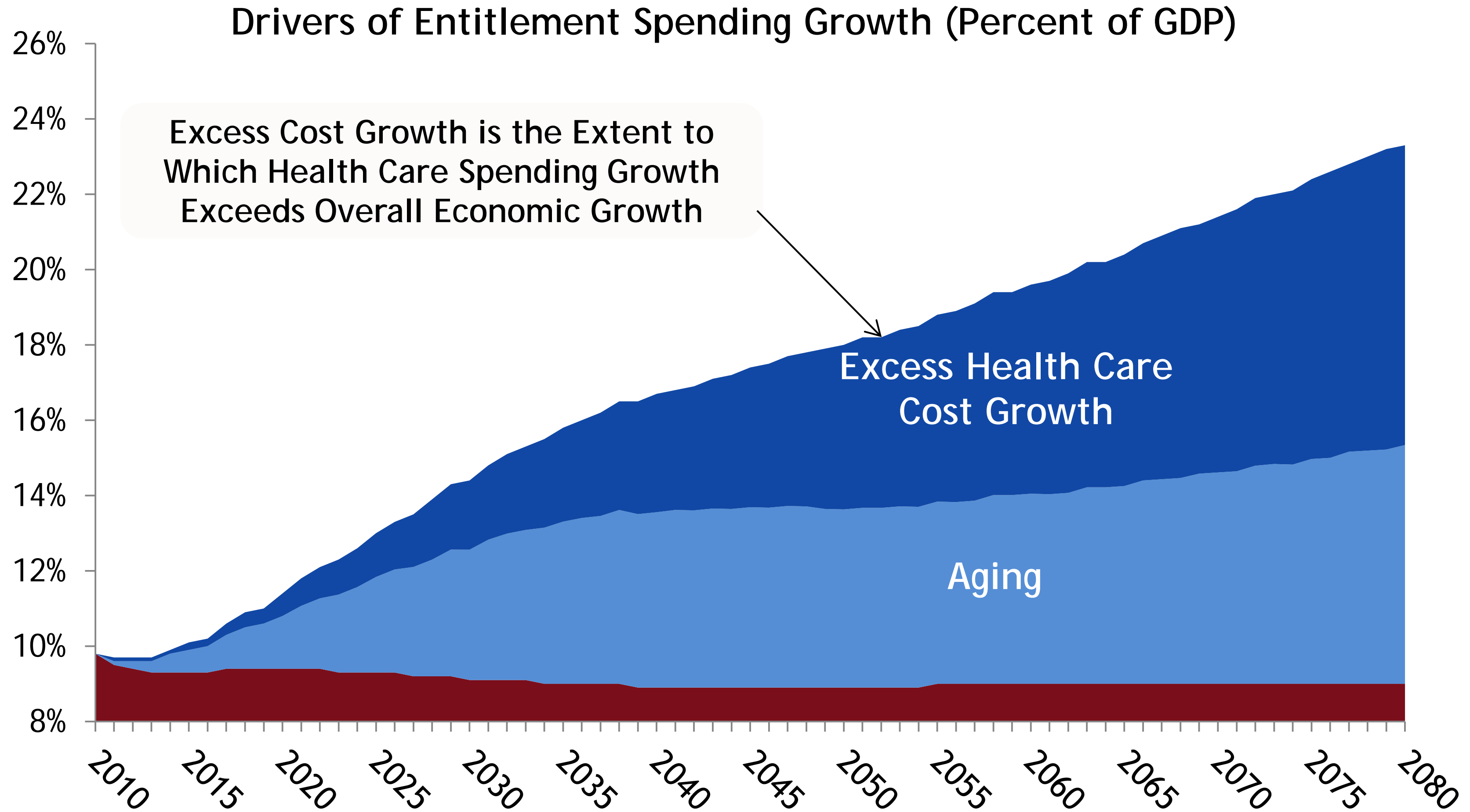

Source: CBO Long-term Budget Outlook, 2011.

Stronger Pressure to Reduce Costs: Fewer Healthy People to Support more Elderly

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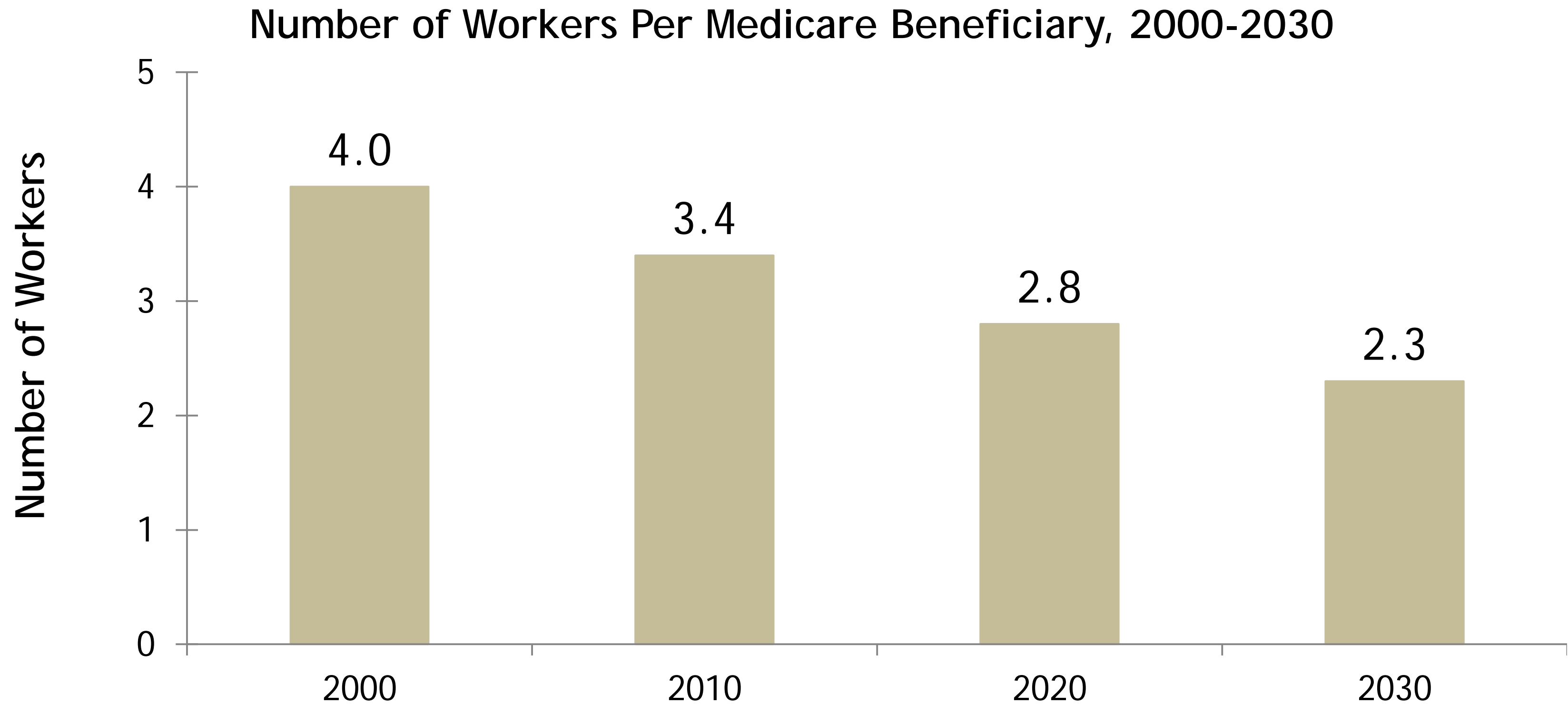

Medicare Part A is financed by payroll taxes of current workers, so an increase in retirees relative to the workforce creates strain on the Medicare trust fund

Source: Annual Report of Medicare Trust Fund Board of Trustees, 2010.

Providers as Critical Players: Physician Supply Fails to Meet Demand

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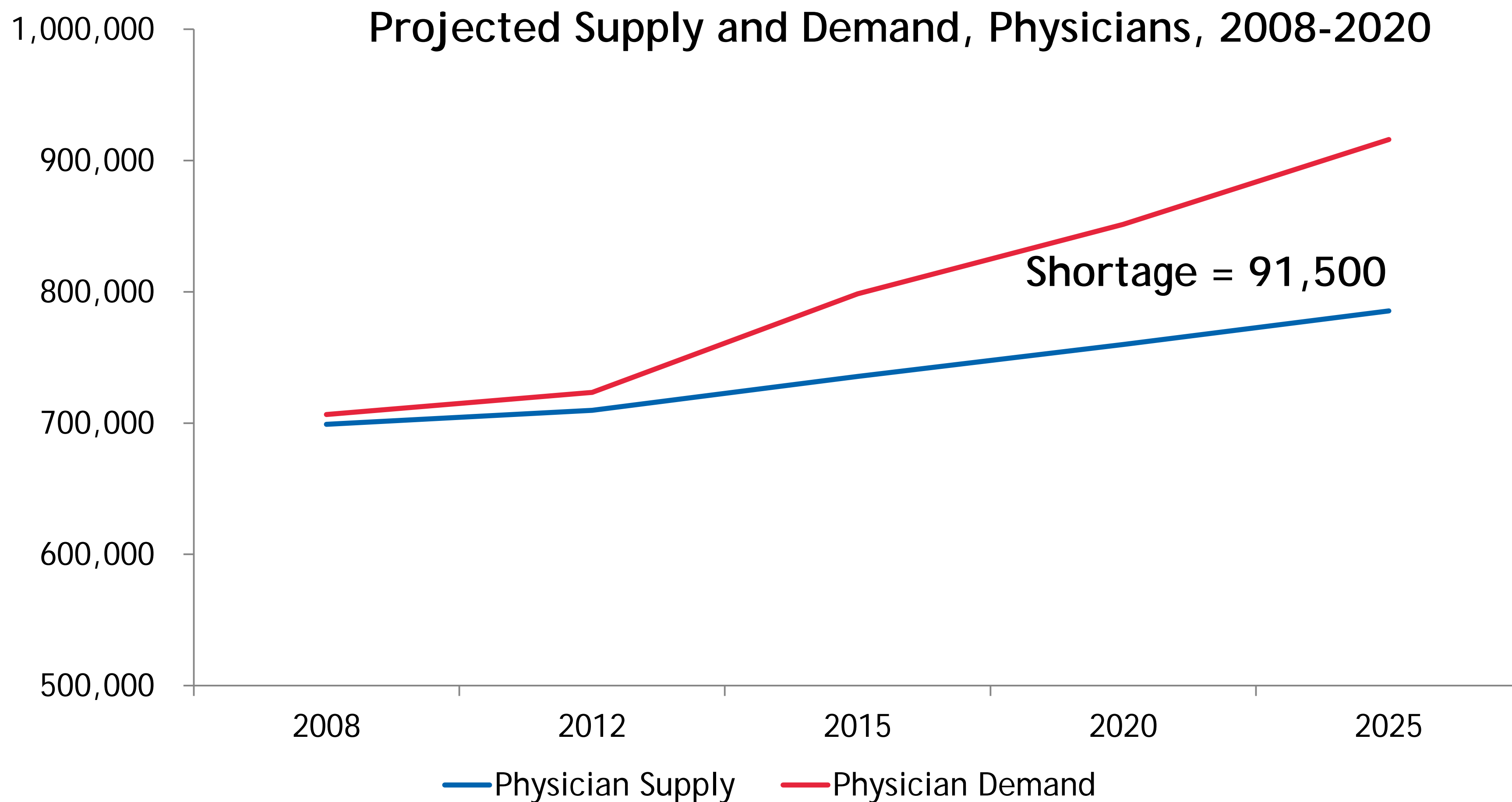

Source: AAMC center for Workforce Studies, June 2010 Analysis
* Total includes primary care, surgical and medical specialties

Election Determines the Future, Decidedly

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Democrat:
Exchanges become reality with broader access, and a new set of cost control drivers, like ACO's and PCMH

Republican:
PPACA is erased, with move to defined contribution in Medicare, and Block Grants for Medicaid

The choice between parties on health care reform had never been as stark as it was last week--- yet both face same demographic truth– aging population

New Reality Leads to Three Key Developments in Apportionment of Health Care Risk

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- In the insured market, employers will try to limit their exposure by adopting consumer driven plans
  - Patients become good shoppers
- Other employers will stop providing health care insurance, give employees a benefit to shop in the exchanges
  - Some might pursue a private exchange with similar outcomes
- Changed circumstance of health insurers will lead them to move to thinner models with risk handed to ACO's
  - Providers will manage care

Competition will ensue between model of reducing costs through shopping consumers vs. managing physicians

Defined Contribution : Jumping Off the Health Care Trend Curve

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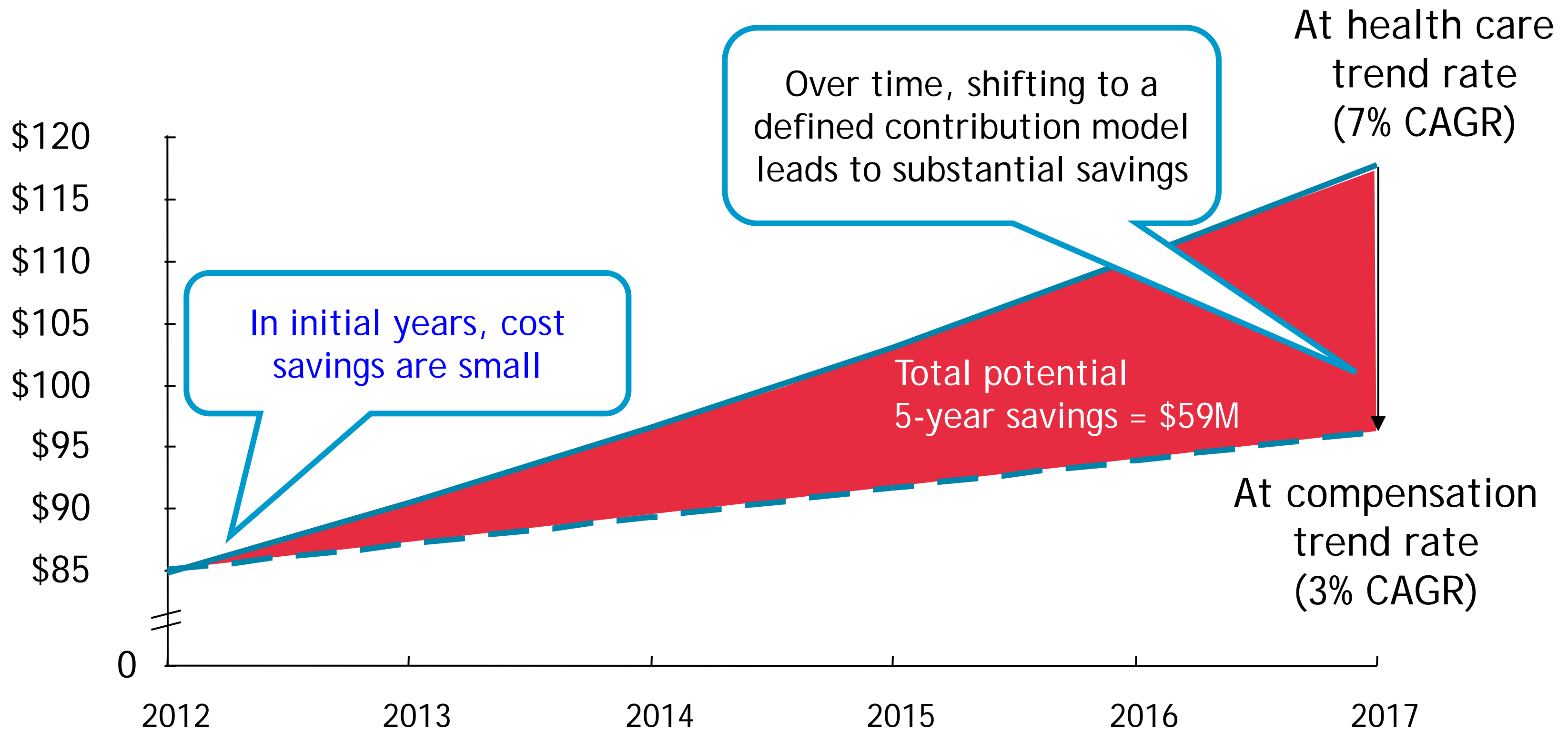

Total estimated employer subsidy (current = $7,000 PEPY) for a typical employer with 10,000 lives at varying growth rates

Year 5 savings of $21M drops to bottom line; equates to $315 million of shareholder value *for every 10,000 employees*

The Shift from DB to DC in Health Care will Follow a Similar Path as Retirement

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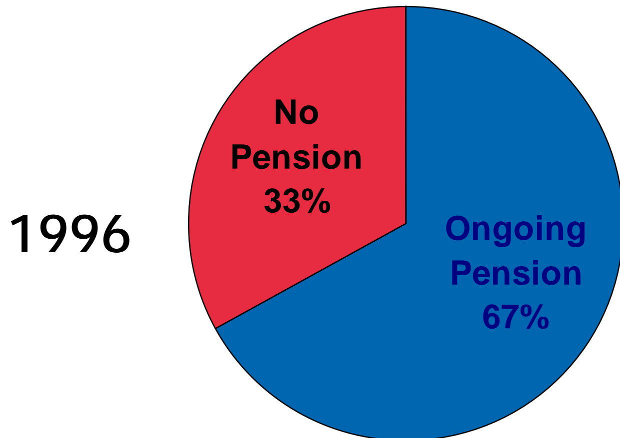
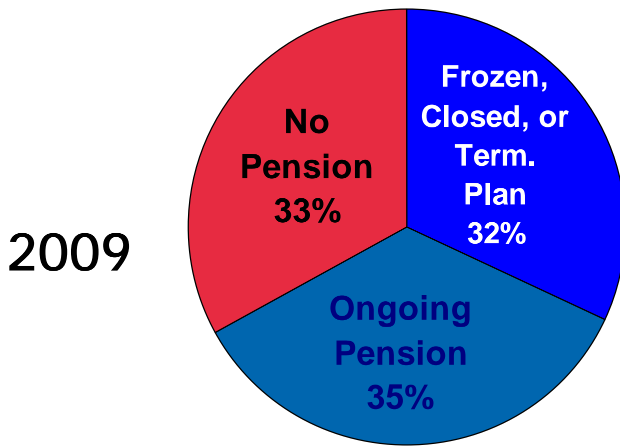
Fortune 500 Pension Plan Prevalence
(Common Group of Companies)

1996

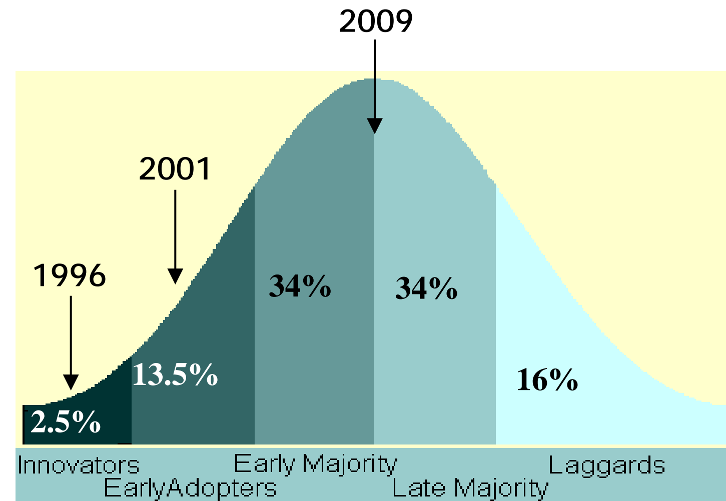


2009



Sources: Hewitt Benefit SpecSelect, Rogers (1995)

- Started with market movers (AT&T, IBM)
- Followed typical innovation curve
- Federal government didn't stand in the way; replacement alternatives existed
- Companies didn't make employees whole



Evolution of Market: Types of Plans Offered

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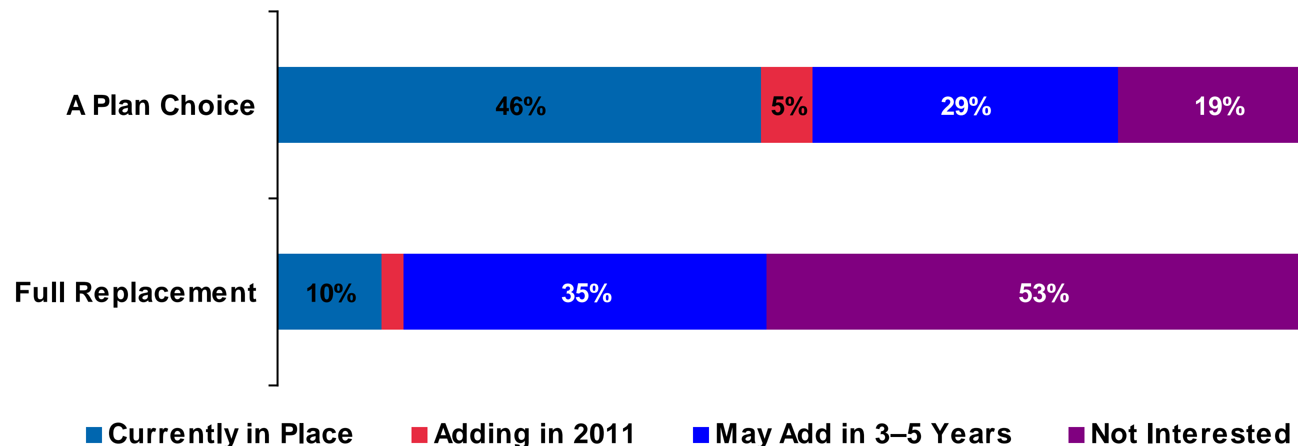
- PPOs continue to be the most prevalent type of health plan offered by employers
- This movement is countered by an increase in the CDHP plans (an eleven percentage point jump from 2010 to 2011)
  - In the next three to five years, 29% of employers plan to add a CDHP as an option, and 35% of employers are considering full replacement CDHP

Offer Consumer-Driven / High Deductible Health Plan As:



Consumers will want Transparency

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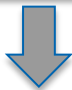
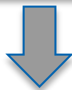
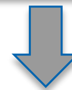
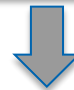
Castlight Health's aspiration:

- Reduce healthcare costs for Users and their employers
- Provide Users with the tools to make well-informed healthcare choices
- Improve healthcare outcomes
- Become Users' trusted guide to the healthcare system

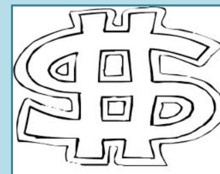





Build a consumer mindset

- User education to teach value of shopping
- Improve User understanding and literacy

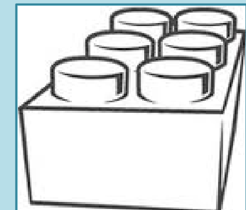
Enable "intelligent" shopping

- Provide necessary data to make an informed decisions
- Create a compelling User shopping experience



Optimize incentives and programs

- Work with employers to create the right incentives to motivate shopping
- Promote other employer programs



Provide a flexible platform

- Offer a consistent experience across payors / plans
- Integrate with other tools/systems to minimize complexity

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Select ACA Policies and Reforms Have Bi-Partisan Support

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Policies Popular Regardless of Party

Republican Policies

Democratic Policies

- Insurance mandates
- Guaranteed issue
- Community rating
- No annual/lifetime limits
- Premium tax credits to afford coverage

Policies Popular Regardless of Party

- No pre-existing condition exclusions
- Dependents on parents plan up to age 26
- Part D donut hole coverage

Republican Policies

- Selling plans across state lines
- Greater use of high-risk pools
- Greater reliance on HSAs/high-deductible plans
- Medicare Premium support
- Medicaid block grants

New Lives and New Funding Sources: Exchanges are Much Different than Traditional Insurance Markets

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Health Plan Underwriting Tools Today*	Individual & Small Group Plans Post - 2014
Vary rates based on range of factors including health status	Rate variation limited to: 3:1 by age 1.5:1 for tobacco use
Health plans are able to deny individuals with pre-existing conditions	Guaranteed issue requires that all applicants be accepted by health plans
Flexibility to set out-of-pocket limits and deductible levels	Bounds on out-of-pocket spending and deductibles**
Plans have flexibility to design high deductible plans or plans with low actuarial values	All plans must hit set actuarial value tiers (platinum, gold, silver, bronze)
No requirements for benefits covered	Plans must cover the essential health benefits

* Select states have outlawed some/all of these underwriting practices already
**Deductible caps are only applicable for small group plans

Comparison of Post-Reform Enrollment Forecasts in Market Segments

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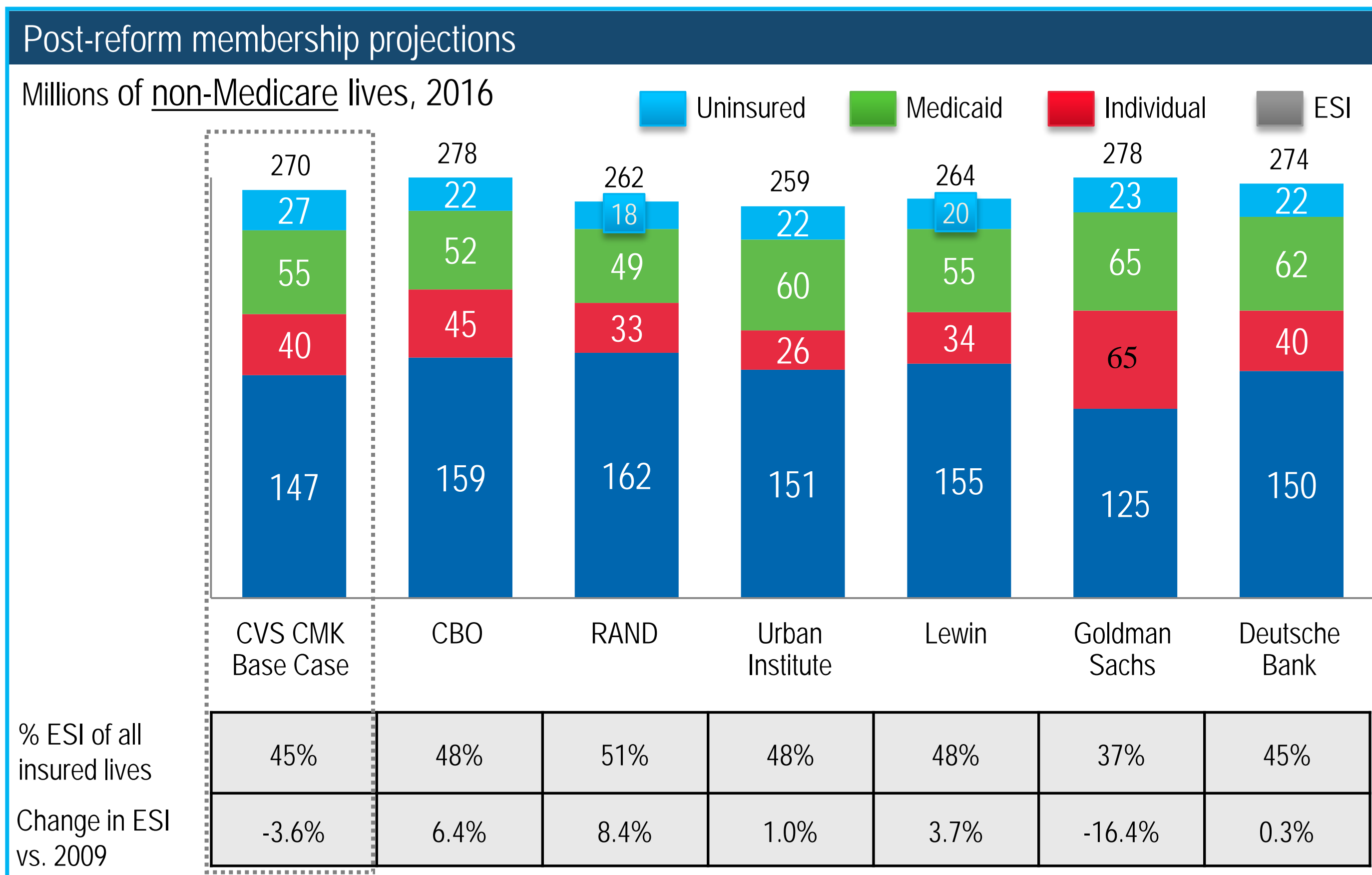

	CVS CMK Base Case	CBO	RAND	Urban Institute	Lewin	Goldman Sachs	Deutsche Bank
% ESI of all insured lives	45%	48%	51%	48%	48%	37%	45%
Change in ESI vs. 2009	-3.6%	6.4%	8.4%	1.0%	3.7%	-16.4%	0.3%

- Sources vary based on:
  - Projections on growth of the economy
  - Salience of individual mandate
  - Medicaid enrollment
  - **Employer assumptions on cost-benefit and viability of Individual market**

Note: Total population varies based on source of population growth; Projections from Urban Institute are for 2010, as if reform were fully implemented; Projections from Lewin are for 2011, as if reform were fully implemented; Rand Individual market includes exchanges only; Goldman Sachs small group excluded from ESI and included in Individual; Percent ESI of all insured lives includes 51M Medicare beneficiaries for each scenario

Source: CVS Caremark; Congressional Budget Office, Mar 2010; RAND Corporation, 2010; Urban Institute, Dec 2010; The Lewin Group, June 2010; Goldman Sachs Research, Jan 2011, Deutsche Bank Research, January 2011

Providers Will Have to Manage Population Risk

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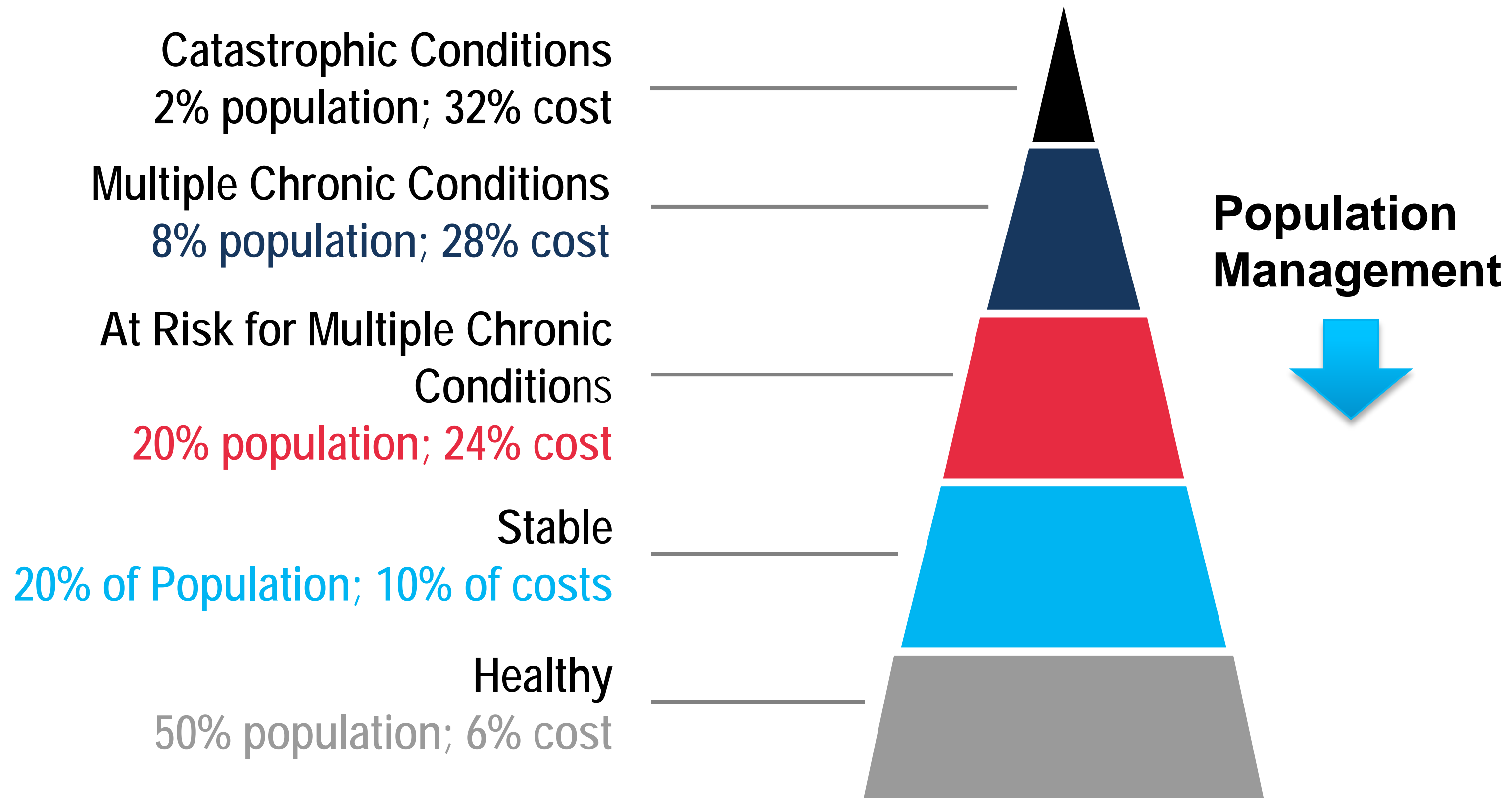

Providers have typicaly provided more care to increase income; in the ACO, that relationship is reversed

Providers Assume Risk

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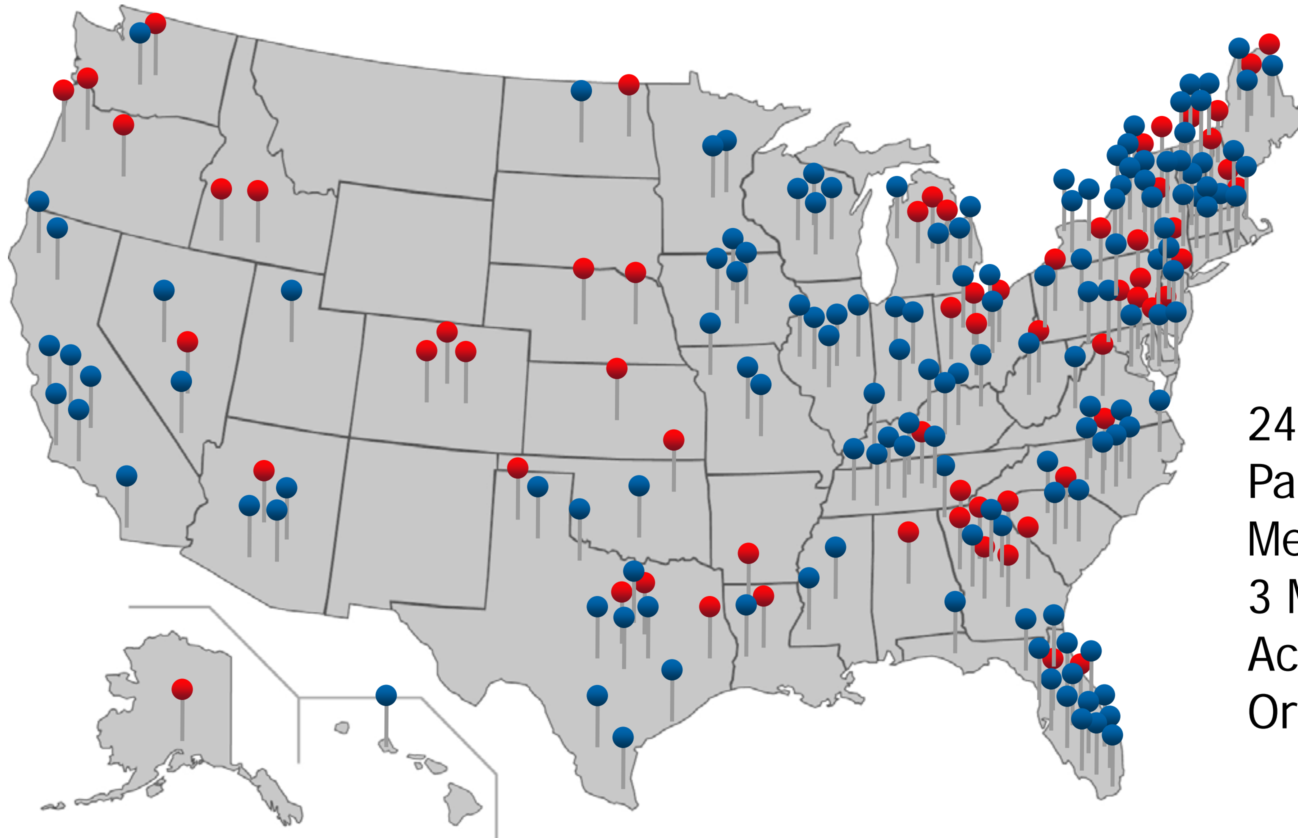

24 Million patients in Patient Centered Medical Homes
3 Million in Medicare Accountable Care Organizations

64 PCMH (Patient Centered Medical Home)
148 ACO (Accountable Care Organizations)

SOURCE: Croshaw 2011

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Providers Are Seeing a Move Away from Fee For Service

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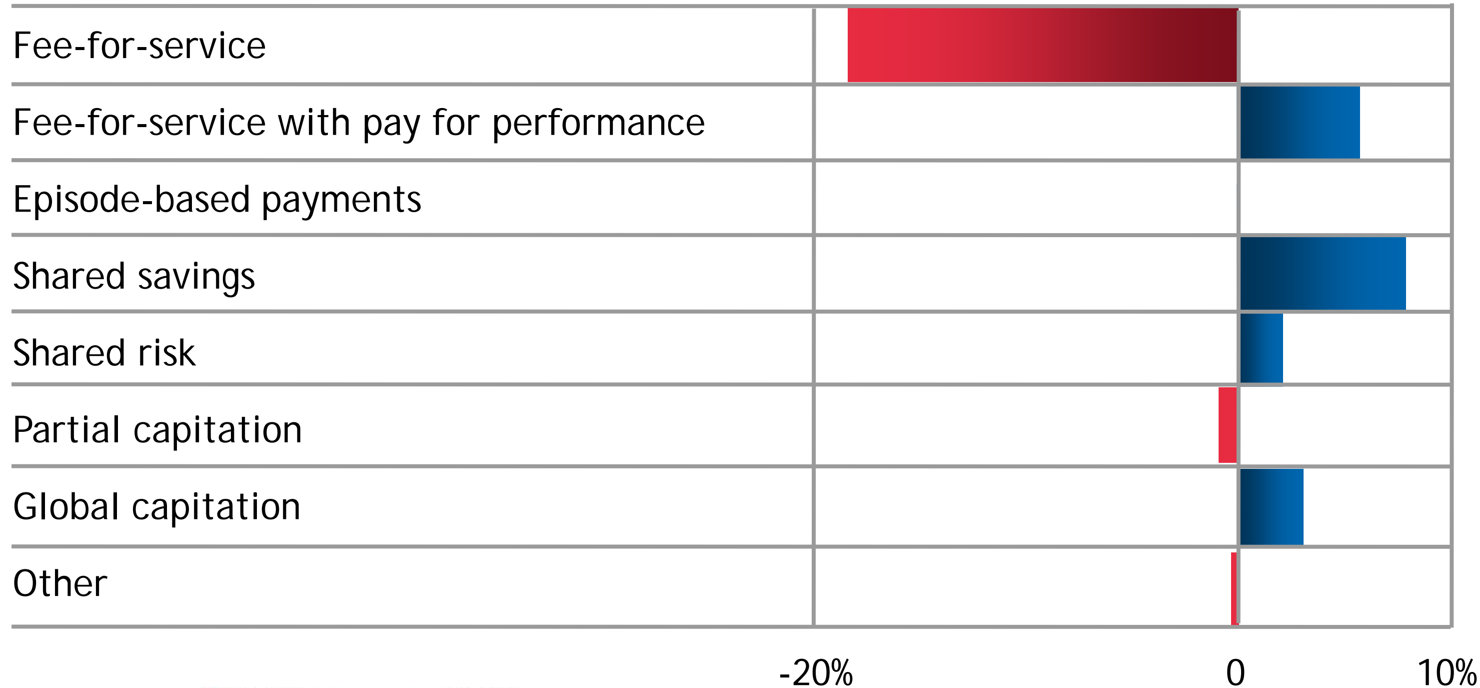

To Summarize the Policy Lay of the Land

- Demographics dictate a harsh economic reality for health care
- Health economic reality demands that both major cost cutting philosophies become more prominent:
  - At risk providers learn to manage care
  - Patients must become consumers
- Election choice was stark, between universal coverage/heavy insurance regulation versus less government/more consumerism
- The political choice favors the former

A Potential New Reality

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- In the exchange and Medicaid market, the offered plans are stringent, feature tailored networks, and offer a competitively low premium
- New regulation makes it difficult to keep plans offered by commercial insurers competitive in terms of premiums
- Math for employers begins to change, and it becomes more financially attractive for them to give employees a fixed dollar amount, and have them seek insurance in the exchange
- Providers will decide it is better to take the entire premium and manage risk than it is to accept Medicaid reimbursement levels
- Acceleration of dumping into exchanges accelerates the move to accountable care
- Shopping by consumers is not part of the ACA architecture

So... How Does Medical Ethics Evolve

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- In the early 2000's, the American Board of Internal Medicine was interested in pursuing a new project on professionalism
- After a certain amount of casting about, decision was made to write a new Charter, working with the American College of Physicians and the European Federation of Internal Medicine
- Work group of 15 people was formed, and over an 18 month period produced the Physician Charter, published simultaneously by the Lancet and the Annals of Internal Medicine in 2002
- Over the next three years, the Charter was adopted or endorsed by every major medical organization/society in the world, and is now widely referred to as the principles which doctors endorse.

Charter: Fundamental Principles

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- Primacy of Patient Welfare
  - Altruistic commitment engenders patient trust
- Patient Autonomy
  - Patient's rights must be respected
- Social justice
  - Fair distribution of health care resources

From these principles flow ten major commitments

Charter Professional Commitments

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- Commitment to Professional Competence
- Honesty with patients
- Patient confidentiality
- Appropriateness of relationships
- Improving the quality of care
- Improving access to care
- Just distribution of health care resources
- Promotion of scientific knowledge
- Management of conflicts of interest
- Professional relationships with colleagues

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Charter Move Ethics Toward Structural Focus

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- In the past, medical ethics emphasize the personal relationship of the patient and the doctor:
  - Honest
  - Do no harm
  - Selfless commitment to the good of the patient
  - Confidentiality, maintain professional relationship
- The Charter addresses all of these, but reflects the American/European recognition that quality and cost pressures required attention to the structure of health care--- quality and allocation of scarce resources
- Charter also accepted the argument that selfless commitment to a patient translated into an ethical commitment to access
- All of this harmonizes well with a health care system that endorses access, but must control costs, and relies on providers to accomplish cost control

Consider New Ethical Issues—ACO Outline

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- Medical center combines hospital and physician staff into a single organization, gets paid to provide care on a capitated basis, $400 per member per month for a commercial population- received from a commercial insurer ($300 pmpm in the Exchange)
- This payment is a global capitiation- meant to pay for all pharmacy, physician visit, hospitalization, care management provided for these patients. The medical center becomes an Accountable Care Organization
- ACO buys data analytics, care coordination, disease management, national network of physicians, and reinsurance from one of many contractors now taking shape
- Emphasis in health care is on encouraging wellness, promoting use of cost effective interventions (medications), preventing hospitalizations and carefully weighing the appropriateness of procedures.

Potential Ethical Controversies

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- Patient has hypertension and coronary artery disease. Currently stable on medications with occasional angina. Family would like the patient to have an angioplasty
- Medical evidence suggests the patient will do just as well on medical therapy as he will do with angioplasty
- Costs of continued medical regimen are a fraction of the costs of angioplasty

Does physician have to disclose the financial conflict of interest?

Should a review committee oversee such cases to ensure care is not being unreasonably withheld?

Structural Ethical Questions

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- Should providers be supporting the Medicaid expansion? Is this an ethical issue?
- Can an erstwhile Accountable Care Organization maintain a fee for service approach, perhaps with a different hospital and a different medical staff?
- As premiums decrease, what should a provider do if quality scores begin to decrease as well?
- Is there an ethical aspect to the impetus to provide health promotion and wellness services?
- When does cost effective care begin to become explicit rationing of care?

Summary

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- Demographics dictate a much different future for American health care
- Economics suggest that that fee for service cannot survive, unless accompanied by much more assertive consumer
- Politics mean that we are headed toward an exchange, individual mandate, ACO dominated future, with pressure on the employer basis for health insurance
- In this environment, new ethical issues, focused on the structure of health care, will present themselves
- Providers should begin to prepare