THE NELSON A. ROCKEFELLER INSTITUTE OF GOVERNMENT

Thinking Ahead: Health Care Trends

For the Albany Medical Center
Horizons Committee

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CURRENT HEALTH POLICY CONTEXT

Observations About the Current Health Care System

- Procedure-based payment system
- Heavily focused on aging population
- Overuse of diagnostics
- Growing chronic disease
- Reliance on inpatient hospital
- Private insurance increasingly expensive
- Inadequate primary care
- Large number of preventable hospitalizations

Recent Changes in State Health Policy

- Increased Medicaid payments for primary care physicians
- Shifting of dollars from inpatient to outpatient care
- Changes in CON process emphasizing community health, reductions in PQI admissions and re-admissions

Promising Trends in Health Policy

- Some attention to causes of spending variation
- Efforts to establish comparative effectiveness
- Efforts to create medical homes
- Investment in information technology

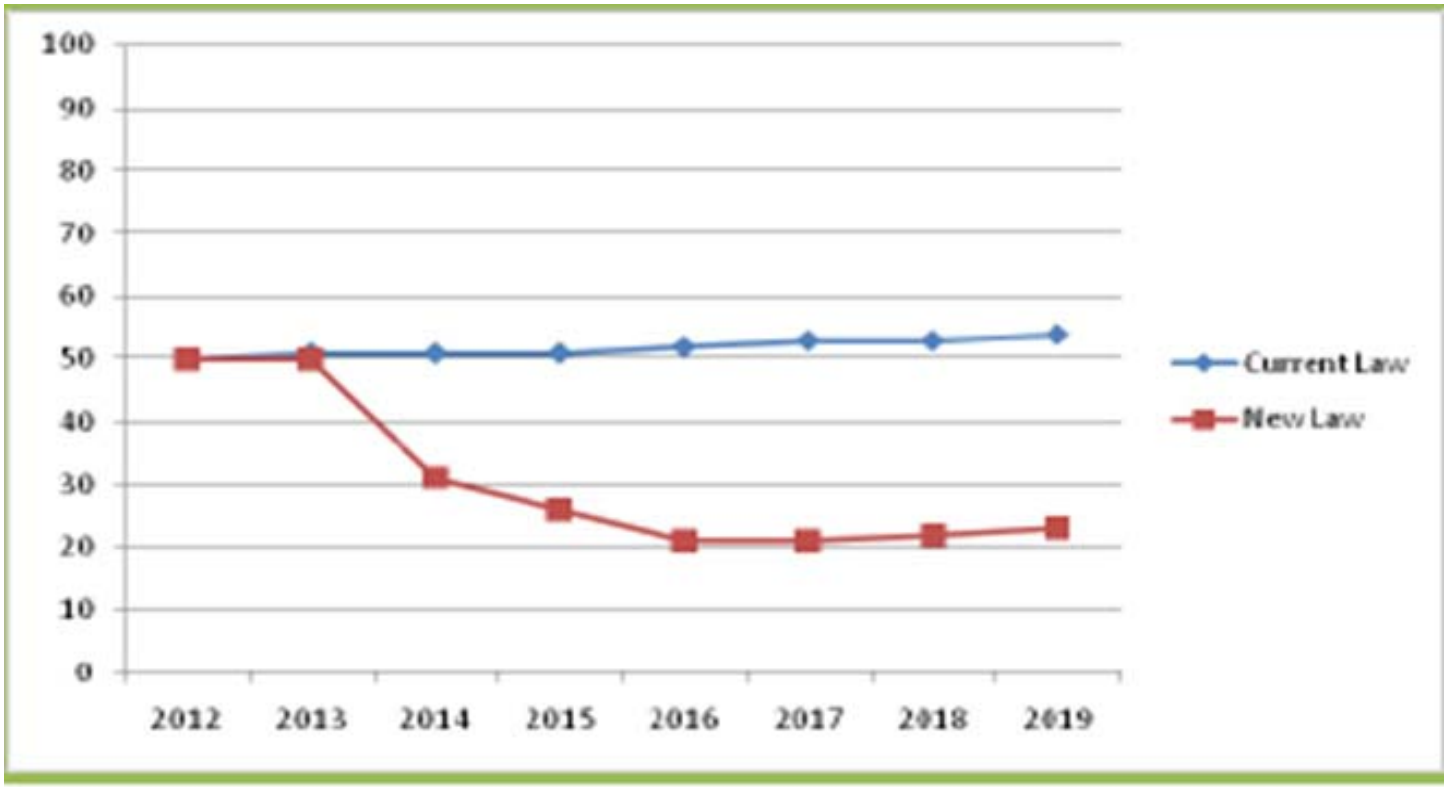
ENTER FEDERAL HEALTH REFORM

Implications of Federal Health Reform

- Largely focused on coverage, insuring at least 30 million more people over time
- No *significant* changes in financing, capacity, access, delivery, quality – but some small steps

Implications of Health Reform (Coverage)

Source: Georgia Health Policy Center Brief, April 9, 2010



***Based on estimates by the Congressional Budget Office. Data was adapted after the reconciliation and shows the non-elderly uninsured including unauthorized immigrants.*

Timing of Coverage Reform Provisions

- 2010 – Bar on lifetime coverage limits; kids not subject to pre-existing condition exclusion; young adults stay on parents' coverage; business tax breaks; insurer premium limits; interim high-risk pools
- 2011 – Interim state exchanges; tax increases to finance reforms
- 2012 – Increased Medicaid payments for primary care physicians
- 2014 – Individual mandate effective; no rejections for pre-existing conditions; state exchanges functioning; Medicare DSH
- 2017 – States pay larger share of Medicaid cost, lose DSH funds

Health Reform Delivery Changes

- Money available for:
  - Creation of teams of medical professionals to provide assistance for primary care physicians caring for patients with chronic ailments
  - Establishment of electronic systems to allow specialists to remotely monitor seriously ill Medicare beneficiaries at local hospitals
  - Program to encourage physicians to take up salaried positions at medical institutions rather than independent medical practices
  - Testing a bundled-payment system in which physicians are paid for the total care of a patient rather than for individual services

Health Reform Financing Changes

- Medicare Independent Payment Advisory Commission
- Reduce Medicare DSH by 75%, then increase based on % of population uninsured/uncompensated care (FY 2014)
- Allow Accountable Care Organizations (ACO) meeting quality thresholds to share in savings
- Better payments for primary care physicians

Health Reform Hospital Financing

- Reduce Medicare payments for specified changes to preventable re-admissions (1/1/2011)
- Reduce payments for hospital-acquired conditions 1%
- Changes in Medicare and Medicaid DSH

What is Missing from Health Reform

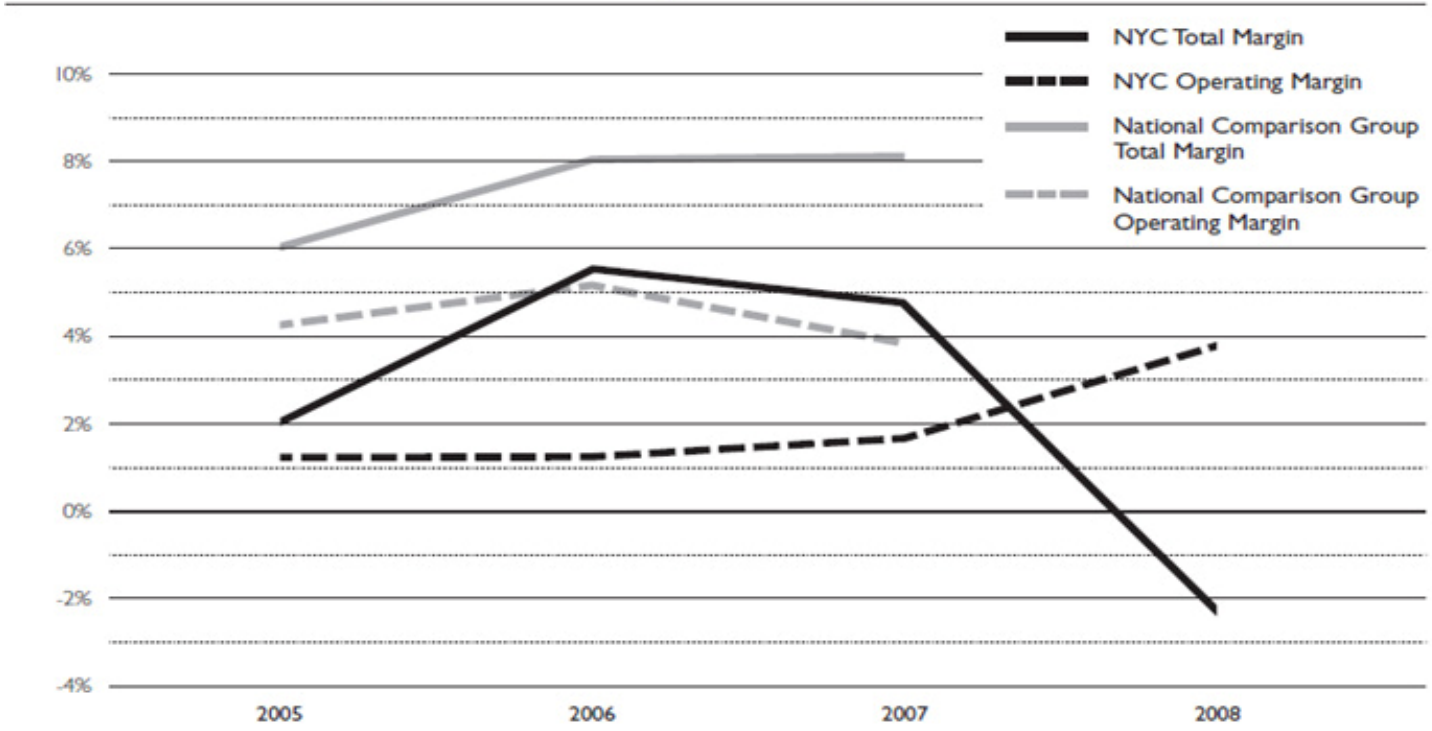
- Coordinated long-term care reform
- Wide-scale payment reform
- Bolstering of capacity
- Wide-scale quality reform
- Consumer empowerment
- Coverage of illegal immigrants
- Long-term cost reductions
- Significant medical malpractice reform

TRENDS TO CONSIDER

Trends in Operating Margins of State's Academic Medical Centers

Source: United Hospital Fund

Figure 6: **Total and Operating Margins at Academic Medical Centers in New York City and National Comparison Group, 2005-08**



Note: At the time of publication, we did not have 2008 financial statements for all hospitals in the national comparison group.

Source: United Hospital Fund analysis of audited financial statements.

Health & Hospital System Indicators

Sources: Kaiser Commission on Medicaid and Uninsured, Commonwealth Fund

	NY	US
Diabetes per 100 adults, 2005	7.8	5.5
% of Overweight or Obese Children	33.9%	32%
% Change Inpatient Hospital Days '99-'07	-12%	-8%
% Change Hospital Outpatient Days '99-'07	10%	10%
% Change ER visits '99-'07	8%	10%
New York State Ranking for Preventable Hospitalization	50	

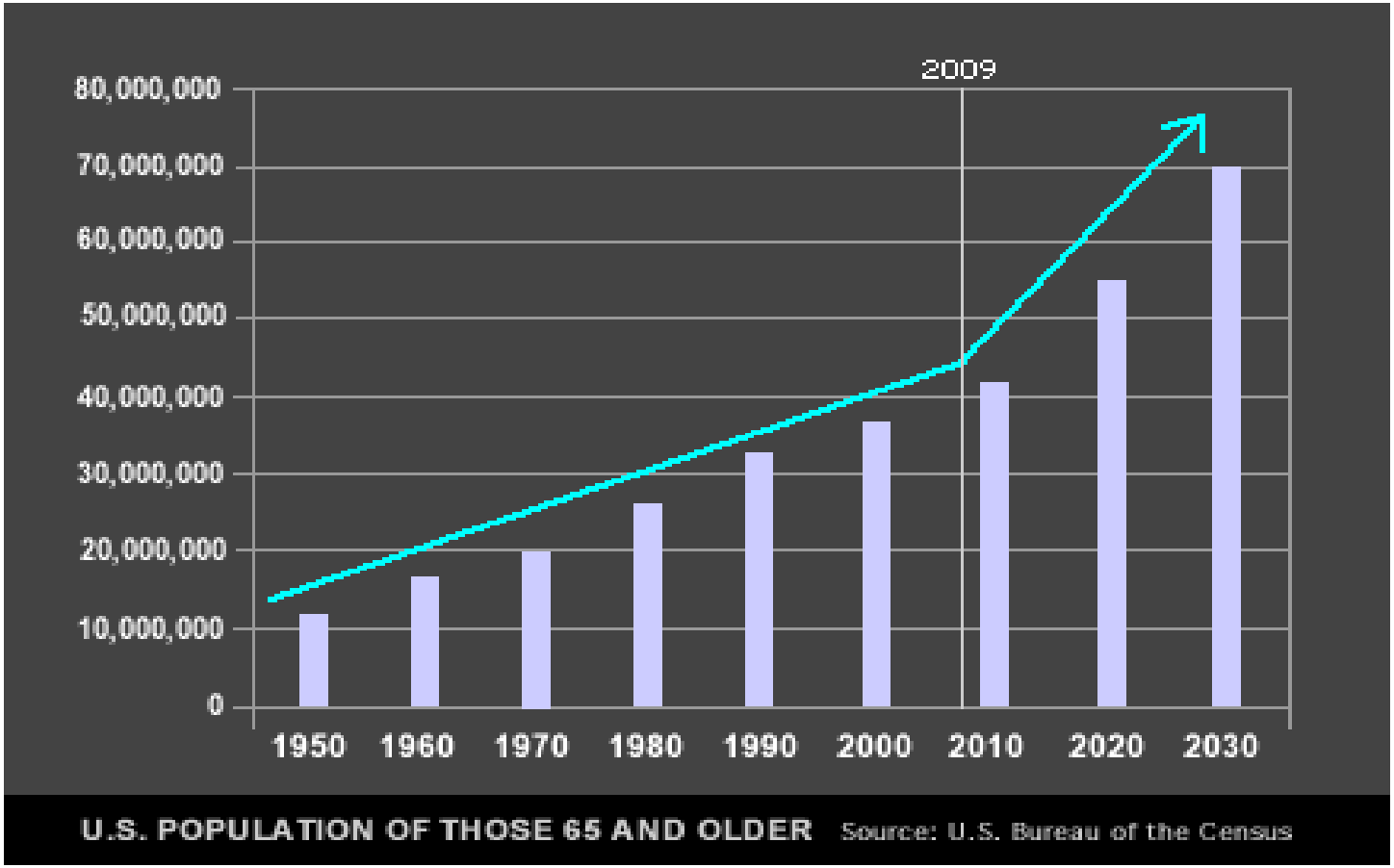
Projected Hospital Care Expenditures by Source of Funds

Aggregate and Per Capita Amounts. Source: CMS

	2009	2019	% Change
Out-of-Pocket	23	36	53%
Private Insurance	268	442	65%
Other Private	27	42	56%
Federal	366	697	90%
State and Local	76	157	107%
Medicare	227	459	102%
Medicaid	134	250	87%

Population Will Be Older

Source: www.transgenerational.org/aging/demographics.htm

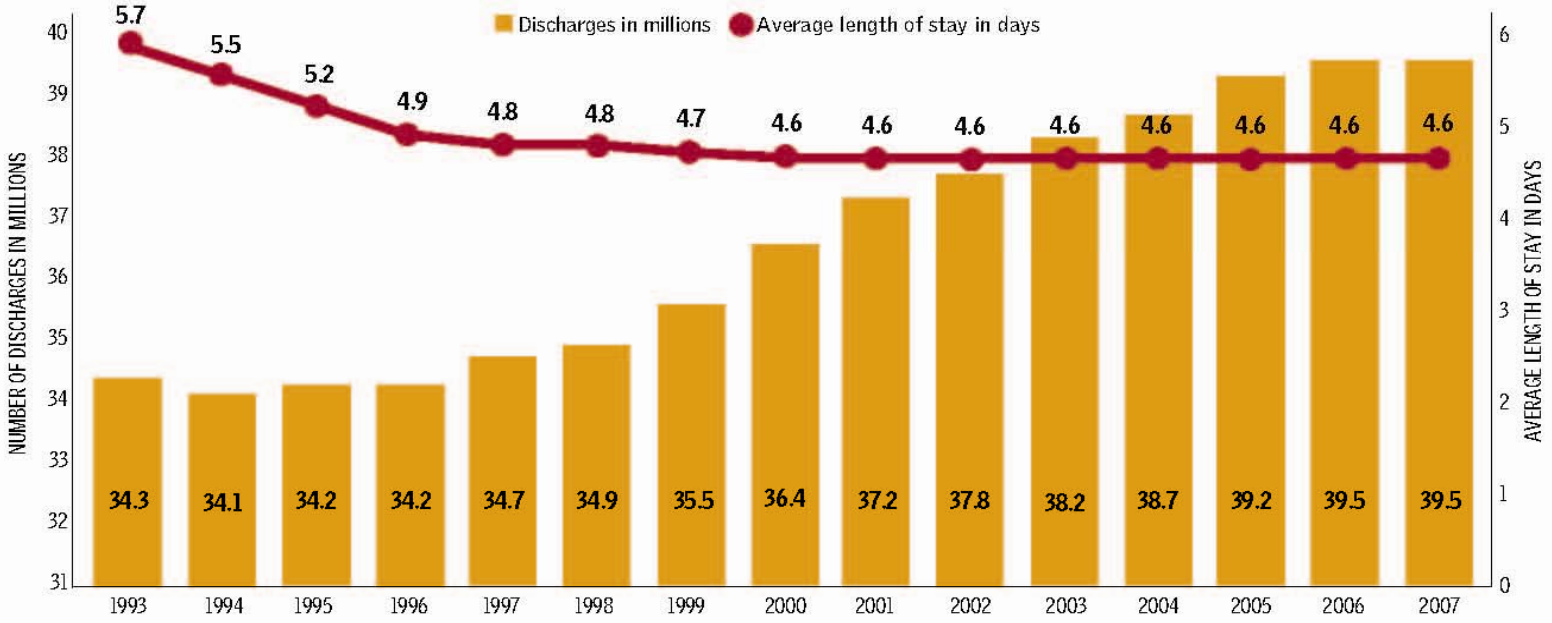


Decrease in ALOS but not Volume

Source: Health Leaders Media Fact File, January 2010

NUMBER AND LENGTH OF INPATIENT HOSPITAL STAYS

The average length of stay in community hospitals in the United States stabilized beginning in 2000, while the number of hospital stays continued to slowly rise. The average length of stay (ALOS) in 2007 was 4.6 days—almost 20% shorter than in 1993, when the ALOS was 5.7 days. From 1998 through 2006, the number of discharges rose by 4.6 million. Growth in the number of discharges (an average of 1.6% annually) exceeded population growth (1.0% annually).



SOURCE: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *HCUP Facts and Figures, 2007*, exhibit 1.2, with support from Thomson Reuters.

PLANNING AHEAD

Post Reform: Things to Consider

- Health care reform does not adequately address, financing, delivery, quality, etc.
- Government will be a larger payer of services but will reduce funding in certain areas
- Ambulatory/outpatient care will continue to grow – but inpatient also steady
- Money available for pilot testing reforms
- DSH financing will change

Health Reform Provider "To-Dos"

- Expand capacity to deal with new insurance enrollees
- Be positioned to take advantage of federal and state funding opportunities
- Make delivery system changes that optimize payment and potential utilization pattern changes (ACO's, more outpatient and primary care)

2020 – Consider Benefits of Changing the Paradigm

Source: Fisher et al., *Health Affairs*, October 7, 2004

- Major U.S. AMCs differ dramatically in the overall intensity of services they provide to similar patients. The increased intensity does not appear to be associated with higher quality of care or to result in better survival.
- Patients in the higher-intensity hospitals simply spend more time in the hospital and intensive care unit (ICU); have more frequent physician visits (especially in the inpatient setting); have more specialists involved in their care; and receive more imaging services, diagnostic testing, and minor (but not major) procedures.

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