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Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

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Editorial

The Decision Is In - Now What?

By David B. Nash, MD, MBA
Editor-in-Chief

Because this is the final issue in our series featuring multistakeholder viewpoints on health care reform, it is only fitting that I devote my editorial to the singular event that colored every article - the Supreme Court decision regarding the constitutionality of the Patient Protection and Affordable Care Act (ACA).

Of all the commentary I read on the topic, *Time Magazine's* “Special Report: The Health Care Decision” struck me as the most balanced and comprehensive. Lead author David Von Drehle’s analysis of the legal gymnastics that turned a potential zero-sum game into a win-win situation was fascinating, as was his profile of the man behind the decision, Chief Justice John Roberts.¹

Controversies will continue to foment, but 2 things are certain: (1) Health care reform as laid out in the contentious ACA is constitutional, and (2) Congress “may not hold states hostage to its every whim,” (ie, the federal government cannot force states to adopt the Medicaid expansion provision, a key element in the pursuit of universal coverage).

So, what does this mean for the average American beginning in 2014?

For the first time in our history, almost everyone will be required to have health insurance. The most notable exceptions are those for whom available coverage options would exceed 8% of their income. Insurers will be required to price and sell policies to everyone, regardless of their health status. For young adults older than age 26, it means paying a financial penalty for being uninsured. For low- to middle-income earners, it means the possibility of qualifying for state Medicaid programs or federal subsidies to help pay for health insurance. For those with “preexisting conditions,” it means that insurance companies will be prohibited from denying insurance and charging higher prices. Because insurers will be

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barred from setting premiums based on risk, it is likely that we all will pay a little more for our health coverage.

The law includes some taxes on industries that are expected to gain from it (eg, medical device makers, pharmaceutical companies). It raises the Medicare tax rate for families earning more than \$250,000 a year and cuts some Medicare spending (eg, reduced reimbursement for the costlier than estimated Medicare Advantage program). Although such taxes and cuts are never popular, they are good policy.

Whether in the government or private sector, those of us who are engaged in health care administration and delivery will continue to work to implement the ACA's ambitious, broad-reaching reforms. Some entities will almost certainly continue to undermine reform efforts; for example, will the 26 states that challenged the Medicaid expansion provision of the ACA now opt out and, if so, how many millions will remain without coverage? The decision

likely will have its most intense effect in the political arena, the upcoming presidential election in particular.

The health economic piece may prove to be the biggest challenge. As economics professor Christina D. Romer observed in her *New York Times* article, "Only the First Step in Containing Health Costs,"² serious discussion of additional cost-saving measures may be a long way off. The reason: Instead of focusing on ways to make the entire health care system more efficient, Republicans seem more interested in limiting the government's share of health care expenditures and Democrats seem more interested in preserving existing government programs.

Given the foregoing "backdrop," I think that the 3 articles in this issue wrap up the series perfectly. The first, "The Supreme Court and Health Reform: A Practical Perspective," is a very timely and comprehensive discussion of the ACA - from its passage, to the Supreme Court

decision, to its implications for all stakeholders. "A Perspective: Through the Eye of the Beholder – Gauging Health Care Value" makes a compelling case for understanding the core components of "value," with particular emphasis on the often overlooked patient/consumer perspective. At first glance, the final article, "A Black Swan Comes to Philadelphia," may seem like mere whimsical exaggeration. But, without the kind of health care system reforms initiated by the ACA, it may become a painful reality.

As always, I welcome comments, suggestions, and questions from our readers. I can be reached at: david.nash@jefferson.edu

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A Message from Lilly

Health Care Reform – Are all the Laws Being “Reformed”?

By Steven C. Benz, Esq.

For the past few months, focus has been on the Supreme Court and what it might say regarding the Affordable Care Act (ACA). Now that it has made its decision, what's next? The first thing to consider is that health care reform is more of a continuing effort than simply an event. Given current politics, new technologies, and a volatile economy, ongoing reform may be the “new normal.”

Going forward, the legal community will be called upon to interpret the continuous change as companies make business decisions and to counsel clients on how to be compliant in this evolving landscape. The latter point is complicated by a legal system wherein the laws governing how companies are to behave often lag behind the realities of the health care environment (an environment that

increasingly is being shaped by the government through laws such as ACA). In many instances, laws were written to address circumstances that are no longer relevant or nonexistent. It follows that another role of the health care lawyer is to assess where and how laws can be reformed.

Before discussing some laws that need updating to further reform, it is

important to note that such hopeful changes will take time. So what should be done in the short run? In order to deal with continuous change, the key is to stay grounded and avoid making legal concepts any more complicated than they are. Many basic concepts that predate the ACA will continue throughout all of the reforms.

As a rule, the following points are at issue: (1) Is the right patient getting the right treatment? (2) Are providers getting the right information in order to make the best decisions for the patient? (3) Are payers paying what they should? (4) Are the financial relationships between the players in the health care sector appropriate and not creating incentives for bad behavior? In the absence of clear guidance, if a contemplated action causes anxiety with respect to the 4 points above, it certainly requires further scrutiny by a legal team and, beyond that, simply may not be the right thing to do.

Our continuous health care reform has not changed any of the above but it has made the situation more acute. In particular, as the government

plays a larger role, federal and state fiscal challenges will continue. Approximately 10,000 people turn age 65 every day. Costs will continue to rise and those who pay those costs will wonder how the money is being spent. This leads to an increased emphasis on compliance.

What laws need reform? We need laws that allow for more collaboration between the participants in the health care industry rather than less. An example of a positive action along those lines is the effort by the Centers for Medicare and Medicaid Services and the Office of the Inspector General to develop fraud and abuse waivers for certain beneficial Accountable Care Organization arrangements. On a less positive note, many potential opportunities between the pharmaceutical industry and providers may be missed when an industry member cannot find a way to enter into a program with a provider and still be able to account for it in its Government Price Reporting in the Medicaid and Medicare programs, if required. Steps must be taken to assure that new scientific information is relayed

quickly and thoroughly to provide decision makers with the most complete information available.

A vibrant marketplace where participants have financial incentives to do better is a great way to improve the abilities of all involved. However, some are concerned that such incentives may lead to bad behavior. Often these fears lead policy makers and enforcement agencies to create and enforce laws that curtail the “right” behaviors to promote good health care. For this reason, some laws actually may be prohibiting reform or moving further away from it. To overcome such skepticism, different stakeholders in the health care sector must agree on a best practice (that existing laws may be preventing) and work together to create legal reform. This reform could allow innovative practices to spring forward, benefitting the health care system and the patients it serves.

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The Supreme Court and Health Reform: A Practical Perspective

By Howard A. Burde, Esq.

On June 28, 2012, the US Supreme Court issued its holding in the initial challenges to the constitutionality of the Patient Protection and Affordable Care Act (“ACA”) in the case of *National Federation of Independent Business (NFIB)*

et al v. Sebelius (Slip Opinion of Case 11-393 on certiorari to the Supreme Court.) This decision will dramatically impact both the future of the nation’s health and the nature of relationships for US health care programs.

The 900-page ACA legislation (or “Obamacare” as it is known, derisively or colloquially depending upon the user’s political perspective) promised to extend universal health insurance coverage to all

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Americans and was touted as the long-awaited health reform to cure manifest problems with cost, access, and perverse incentives in the health care system. In reality, it was and is far less. In fairness, it was and is a consequential attempt to extend health insurance coverage to a large number of adults formerly not covered by insurance, either by choice or circumstance. However, the ACA provides little in the way of systemic, structural, or payment reform. Thus, the ACA is about coverage, not reform. The purpose of this article is to describe the components of the ACA at issue in the *NFIB v. Sibelios*, and to discuss the implications of the decision on the ACA itself, state and federal governments, consumers, employers, providers, and payers.

Background

The ACA attempts to increase access to health insurance coverage while expanding federal and private health insurance market requirements, and requires the creation of health insurance exchanges (HIEs) to provide individuals and small employers with access to insurance. Among other provisions, ACA increases access to health insurance coverage by: (1) expanding Medicaid eligibility by mandating that individuals obtain health coverage and that employers provide it, (2) extending funding for the Children's Health Insurance Program (CHIP), and (3) subsidizing private insurance premiums and cost sharing for certain lower-income individuals enrolled in exchange plans. These costs are projected to be offset by increased taxes and other revenues and reduced Medicare and Medicaid spending. The law also includes measures to collect information and to explore new ways to enhance delivery and quality of care.

The major expansion and reform provisions in ACA take effect in 2014. State Medicaid programs will be required to expand coverage to all eligible nonpregnant, non-elderly legal residents with incomes up to 133% of the federal poverty level (FPL). The actual percentage works out to be 138% because the first 5% of income is disregarded for Medicaid eligibility determinations. The federal government will initially cover all the costs for this group, with the federal matching percentage phased down to 90% of the costs by 2020. The law requires states to maintain the current CHIP structure through fiscal year (FY) 2019, and provides federal CHIP appropriations through FY2015, thus extending CHIP funding by 2 years.

States are incentivized to establish HIEs that provide access to private health insurance plans with standardized benefit and cost-sharing packages for eligible individuals and small employers. In 2017, states may allow larger employers to purchase health insurance through the exchanges, but are not required to do so. The Secretary of Health and Human Services (HHS) is empowered to establish HIEs in states that do not create their own approved exchange.

Premium credits and cost-sharing subsidies will be available to individuals who enroll in HIE plans, provided their income is generally above 100% and no more than 400% of the FPL and they meet other requirements. Also beginning in 2014, most individuals will be required to have health insurance or pay a tax penalty (the "individual mandate"). Employers with more than 50 employees that do not offer health insurance may be subject to penalties. Such employers that do not meet the law's requirement by offering qualified health insurance products, or whose

full-time workers enroll in HIE plans and receive premium subsidies, will pay a penalty.

ACA's federal health insurance requirements are further expanded in 2014, with no annual dollar limits permitted on essential health benefits and no exclusions permitted for preexisting conditions or the patient's age. Plans offered within HIEs and certain other plans also must meet criteria of essential benefit standards (eg, covering emergency services, hospital care, physician services, preventive services, prescription drugs, and mental health and substance use disorder services). Premiums may vary by limited amounts based on age (3:1), family size, geographic area, and tobacco use (1.5:1). Plans must sell and renew policies to all individuals and may not discriminate based on health status.

Employers face additional – and costly – new requirements such as new increases in benefits and premium costs, and new taxes on premiums passed through to employers. Moreover, the ACA contains a number of new "soft costs" that are rarely discussed in the public arena but which add significantly to the employer burden regardless of the insurance changes (eg, withholding changes, mandates for reporting the value of health coverage, uniform summary of benefits and coverage, summaries of material modifications, auto-enrollment, new taxes on high earners, new taxes on high-benefit plans).

(Note: The material in the foregoing section is derived from the language of the ACA and from Congressional Research Services reports, most notably *PPACA: A Brief Overview of the Law, Implementation, and Legal Challenges* [Chaikind H, et al. CRS March 2, 2011].)

Summary of the Supreme Court's Decision in *NFIB v. Sebelius*

The Supreme Court considered 4 questions:

1. Does the Anti-Injunction Act preclude consideration of the mandate as a tax prior to 2014?
2. Is it constitutional for Congress to mandate that all individuals purchase or maintain health coverage?
3. If the mandate were unconstitutional, would it be severable from the remainder of the ACA, or would the entire Act be unconstitutional?
4. Is the Medicaid expansion under the ACA constitutional?

Initially, the Supreme Court held that the Anti-Injunction Act does not preclude consideration of the mandate as a tax because Congress called the mandate a penalty.

Having satisfied the threshold question, the Supreme Court decided that the individual mandate was unconstitutional under Congress' Commerce Clause powers, but that it could be read as a tax and therefore was constitutional under Congress's power to tax and spend. This is the most controversial component of the decision. Indeed, only Chief Justice Roberts held this opinion. Four Justices agreed that the individual mandate was unconstitutional under the Commerce Clause (Kennedy, Scalia, Alito, and Thomas), making a majority for that part of the Chief Justice's decision. Even though they believe it is constitutional under the Commerce Clause, the 4 other Justices (Ginsberg, Breyer, Kagan, and Sotomayor) agreed to uphold the individual mandate as a tax, making a

majority opinion to uphold the individual mandate. Because the individual mandate was ruled constitutional, the severability question was moot.

Finally, the court held that Congress could not condition a state's receipt of funds for an existing program or the expansion of that program or a new program. Therefore, the Medicaid expansion to new populations was ruled to be unconstitutional if mandatory for states. States may opt to expand, but cannot be forced to do so.

What the Supreme Court's Decision Means

The Individual Mandate

To understand the Court's decision, it is helpful to understand the underlying provision of the Constitution. The opening paragraph of Article I, Section 8, which provides the powers of Congress, states that, "Congress shall have the power to lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and general welfare of the United States." Several additional clauses "enumerate" the powers of Congress to which the opening paragraph applies, and among these enumerated powers is the power under Article I, Section 8, Clause 3, to "regulate commerce with foreign nations and among the several states and with Indian tribes." This is known as the "Commerce Clause."

In defending the mandate, Congress and the Obama administration asserted that the Commerce Clause was plenary and without limitation because every act or non-act would impact commerce. Indeed, the history of the Supreme Court Commerce Clause jurisprudence since the New Deal is one of steady expansion of Congress' authority to regulate under the Commerce Clause. Chief Justice Roberts

noted that "the power of Congress over interstate commerce is not confined to the regulation of commerce among the states but extends to activities that 'have a substantial effect on interstate commerce.'"

The Chief Justice further noted that Congress's power is "not limited to the regulation of an activity that by itself substantially affects interstate commerce, but also extends to activities that do so only when aggregated with the activities of others." "But," the Chief Justice noted, "Congress has never attempted to rely on that power to compel individuals not engaged in commerce to purchase an unwanted product."

The court held that the power to regulate commerce "presupposes the existence of commercial activity to be regulated." There must be actual activity and Congress does not have the authority to compel activity to then regulate. Moreover, the Chief Justice held that Congress cannot regulate individuals because they are not engaged in an activity, or as he stated, "doing nothing." "Every day individuals do not do an infinite number of things" and "Congress is not empowered to regulate that absence of activity or to mandate activity under the Commerce Clause."

By contrast, Congress' power to lay and collect taxes is considered plenary. It is accepted jurisprudence that Congress' power to tax is virtually unlimited constitutionally, but is generally limited politically. The Chief Justice notes that the ACA does not describe the penalty for not having health coverage as a tax. Indeed, central to the political debate leading to passage of the law was the insistence of Congress and the President that the law did not raise taxes, but that the mandate was a "shared responsibility payment." The fear, of course, was that

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if the mandate were considered a tax, it would have been more difficult to get the votes to pass the bill.

On July 24, 2012, the Congressional Budget Office announced that the decision itself changed the tax calculus to add \$4 billion in new taxes on businesses and \$1.5 billion in new taxes for individuals. In fact, ACA raises over \$1 trillion in taxes, inclusive of the mandate being a tax, and diverts over \$500 billion from the Medicare program.

Ultimately, this part of the decision means that the mandate tax is now subject to a simple calculus for individuals. The question becomes one of whether it is more cost-effective to obtain coverage in advance or to risk paying the penalty and obtain the coverage only when needed. Because of the guaranteed issue provisions of the ACA, an individual can obtain coverage at any time. Without an enforceable law, there is only a tax to compel an individual to obtain coverage prior to an illness.

In a broader sense, the holding means that future expansions of federal authority likely would be justified as constitutional under the taxing and spending power, a higher bar to reach politically.

Medicaid Expansion

The Supreme Court also held that Congress could not mandate state expansion of the Medicaid program to new populations. Recall that half of the anticipated additional coverage, approximately 16 million lives, would have been through the Medicaid program. Given the problems with the Medicaid program as currently structured, 27 states representing approximately 40% of the anticipated new lives challenged the expansion.

Although politics may have played some part in the challenge, the Medicaid programs in most states are problematic from both administrative and budget perspectives. Even with a federal promise to pay for the increase of nearly all of the Medicaid expansion in the short term, adding 16 million more lives to the program was and is not considered practical for the governors of those states.

The Supreme Court's decision validated the challenge, reviving a state's ability to determine whether or not to participate in a federally funded program. To date, 7 states with 20% of the anticipated new lives to be covered have already opted out and another 9 are considered likely to do so. Two reasons predominate. First, the federal promise of full funding is ephemeral. Once an entitlement is in place it cannot be withdrawn without a huge political and legal battle. If the federal money were to be reduced, the states would be stuck with the bill and forced to either generate revenue through taxes or reduce other programs (eg, infrastructure, transportation, education) to pay for the federal mandate. State budgets are littered with unfunded or partially funded federally mandated programs. Adding another at a time when state budgets are already stressed makes no fiscal sense. Second, the limited budget reduction proposals from the Obama administration already call for a reduction of federal financial participation for the Medicaid expansion and for CHIP participation. Even though the Obama administration has not passed a budget for 3 fiscal years, it has already signaled to the states that the federal matching funds are at risk. Under such circumstances, it can be argued that implementation of the Medicaid expansion is political, while declining to do so is pragmatic.

The Supreme Court's decision on the Medicaid expansion has further implications for the relationship between the federal and state governments. Programs such as nutrition, education, transportation, aging, and Medicaid are administered by states under formulas that include federal financial participation. The states must submit extensive "State Plans" for federal approval in order to draw down the federal funds. The states also file for waivers from federal requirements in order to run the programs in more effective ways. By limiting the federal leverage over states, the Supreme Court has created the opportunity for states to seek federal funds without significant bureaucratic conditions and with dramatically new structures.

The states argue that, being closer to the delivery of services, they know how to best deploy the resources without a layer of bureaucratic oversight. Indeed, there is no evidence that state bureaucrats are any less educated, dedicated, or able than federal ones. State bureaucrats simply work for less money in less exciting places. Effectively, the Court's decision creates the conditions for a new balance of federal and state authority with respect to federally funded programs. Note that several states are in the process of structuring alternatives to the Medicaid expansion for federal consideration. These alternatives may include revised benefit structures for both the new and existing components of the Medicaid population, such as the expansion of existing but less expensive programs like SCHIP, mini-med or catastrophic programs, or yet undetermined choices. This leads to issues of the flexibility of the ACA language to permit alternative structures and the willingness of the Department of HHS to grant waivers for restructuring. Ultimately, the

ability to offer alternatives is a positive opportunity to reach toward universal coverage without undermining state fiscal structures.

Impact on Consumers and Employers

The net impact of the Supreme Court decision on consumers is to make the individual mandate less compelling. Because the tax is both low and not subject to enforcement, there is little to compel individuals to purchase insurance before they need it. The annual tax for not having minimum essential coverage will be the *greater of* a flat dollar amount per individual *or* a percentage of the individual's taxable income. For any dependent younger than age 18, the penalty is one half of the individual amount. The flat dollar amount per individual is \$95 in 2014; \$325 in 2015, and \$695 in 2016. After 2016, the flat dollar amount is indexed to inflation. The flat dollar penalty is capped at 300% of the flat dollar amount. The percentage of taxable income is an amount equal to a percentage of a household's income (as defined by the Act) that is in excess of the tax filing threshold (phased in at 1% in 2014; 2% in 2015; 2.5% in 2016). The tax will be reflected as a federal tax liability on income tax returns and is enforced by the Treasury. Individuals who fail to pay the penalty will not be subject to criminal penalties, liens, or levies.

The essential benefit packages mandated by the ACA are very rich and include the costs associated with taxes on medical devices, on premiums, and on executive policies. So, individuals have a choice: They can purchase a rich benefit package with associated taxes from day 1, or risk paying a small tax and either purchase the insurance as they need it or purchase less expensive but adequate coverage outside the HIEs.

If an average individual policy is \$500 per month, skipping even 1 month makes economic sense. Because preexisting conditions cannot be used to deny coverage, an individual can wait until he or she is diagnosed with an illness. Other than to cover a potential accident that requires emergency room care, it does not make economic sense to purchase coverage. Even then, other insurance (eg, automobile, homeowners) might cover many of the potential accidents that would require emergency room care. Of course there are also strong reasons to obtain health insurance - in addition to satisfying the tax mandate, qualified coverage provides both peace of mind and rich benefits that help avoid preventable conditions and maintain health status.

It is worth noting that under the Medicare Part D benefit, those who decline to obtain coverage until they need it pay a surcharge, making it less economically beneficial to wait. This disincentive to wait combined with the fact that the eligible population is elderly and more likely to require prescription drugs on a regular basis has resulted in close to universal adoption and far lower than anticipated costs.

For employers, the economics are similar. The tax incentive applies to firms with more than 50 employees. Companies that do not offer health insurance and have at least 1 employee receiving insurance subsidies must pay a tax of \$2000 per employee not covered by insurance (excluding the first 30). For example, a firm adding a 51st employee would pay \$42,000 in new annual taxes plus an additional \$2000. Effectively, a company must view the new employee as worth more than \$42,000 in additional net profit (over the amount needed to justify the new employee in the first place) or the cost of providing health

coverage to all employees, a massive disincentive for small businesses.

Employers are not required to pay an assessment for employees who work less than 30 hours per week or employees hired for less than 120 days, seasonal employees, or retail workers hired exclusively during the holiday season. Taken to extremes, the employer-related mandates may lead to a system wherein people are employed by smaller employers or are employed on a part-time rather than full-time basis. Current employees or distinct components of businesses would be spun off into smaller companies or treated as independent contractors.

Large employers will need to make a slightly different calculation - determine the per-employee cost implications of providing health coverage and compare that cost to the cost of dropping the plan, paying the penalty, and reimbursing the employee for his or her employee mandate fee. Employers with more than 200 employees must automatically enroll all full-time employees as soon as they are eligible. The Supreme Court did not change this fundamental calculation but, by upholding the law, it forced companies to focus on the decision of whether or not, or how, to provide health coverage for employees. Because the first year of the Employer Mandate is 2014, the decision must be made in time for a benefits selection process in the fall of 2013.

All larger employers must report, but not tax, the cost of providing coverage on the W-2 forms of employees. More highly compensated employees are subject to additional Medicare payroll taxes of 3.8%. The new portion of the payroll tax will be devoted to ACA implementation. Smaller employers are entitled to grants and other incentives to provide care and will be eligible to obtain coverage through the state HIEs.

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Payers and Providers

Payer community support for the ACA was based on an understanding that the individual mandate would provide millions of new lives to cover; therefore, the mandatory essential benefit packages, medical loss ratio, premium taxes, guaranteed issue, and prohibition on preexisting conditions and on annual and lifetime benefits would be less pressing. Nothing in the law prohibits health plans from developing actuarially sound premiums to cover those costs, and nothing in the law actually limits costs. Frankly, health plans make money on each life and the higher the premium, the higher the profit. If a problem exists, it is with those individuals who obtain coverage only when they need it - and therein lies the rub of the Supreme Court opinion for payers. Because the decision makes it more likely that individuals will not obtain coverage until they need it, health plans will be unable to anticipate reserves for such individuals, adding uncertainty to the premium calculation. And fewer individuals obtaining coverage means less profit.

Because universal coverage was the incentive for hospitals to accept

cuts in Medicare and Medicaid reimbursement, hospitals will suffer. The cuts include a 2% sequestration across the board; reductions in market basket updates for hospital care; decreases in imaging reimbursement; penalties for “potentially avoidable readmissions”; Disproportionate Share hospital reimbursement cuts; value-based purchasing for cardiac, surgical, and pneumonia services; hospital-acquired condition penalties; and the bundling of post-acute care services.

To the extent that states decide not to expand Medicaid, and individual and employer mandates do not lead to anticipated increases in covered lives, the Supreme Court decision likely will have an adverse impact on hospitals. The reduction in anticipated covered lives and the willingness of Congress and the Department of HHS to reconsider the reductions will determine the extent of the adversity.

Conclusion

Although the public and media focus on the Supreme Court’s *NFIB v. Sebelius* decision has been on determining winners and losers, a far more interesting

dynamic is apparent. Inside Washington, DC, the bill’s proponents and opponents remain unchanged. Outside the “Beltway,” the states, businesses, and individuals dealing with the ACA are focused less on the politics and more on the financial, legal, and administrative implications. The ACA is an ambitious piece of legislation that covers a great range of health care issues. Its attempt to reach near universal coverage is a goal to which there is almost no opposition, yet the means to achieve it are incredibly burdensome. The wisdom of the Supreme Court’s decision is that it creates the atmosphere for states to develop more creative approaches and forces the issue with respect to individuals obtaining coverage. However unintended, the decision is spurring a reconsideration of the means to achieve universal coverage.

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DISCLAIMER: This article does not constitute legal advice. For advice on the provisions of the ACA, please contact your own attorney.

A Perspective: Through the Eye of the Beholder – Gauging Health Care Value

By Paul Wallace, MD

Introduction

Few concepts in health care have promoted more discussion, prompted more interventions, and sustained more controversy than the desire to objectify and measure value. Measures of diverse attributes of value have multiplied while conceptual and action-oriented frameworks to position measurement findings and to reconcile ambiguities compete for attention. Refinement in measure development and validation is

occurring in concert with generalized agreement that the ability to robustly and accurately measure attributes of value is core to evolving and sustaining an effective and equitable health system. However, as the desire and ability to reflect aspects of value has advanced, the importance of linking the meaning of value to the needs and beliefs of various key stakeholders in the health care system also has escalated. In short, the more we learn about measuring value, the more there is yet

to learn about ensuring that the results of measurement are broadly informative and engaging. The following identifies some considerations about, and current gaps in, what may be involved in more completely pursuing broadly engaging value measurement and realization.

The Need to Create and Demonstrate Value... Now, More Than Ever...

The importance of demonstrating the value of health care services and delivery

system change has intensified with the passage of the Patient Protection and Affordable Care Act (ACA) health reform legislation in 2010, in combination with the other extraordinary public investments in the last decade in health services (eg, the Medicare Prescription Drug Benefit part of the 2003 Medicare Modernization Act, elements of The American Recovery and Reinvestment Act of 2009 and its Health Information Technology for Economic and Clinical Health Act).

A public focus of this amplified scrutiny is the Centers for Medicare and Medicaid Services' Center for Medicare and Medicaid Innovation, with its mission of "Better health care, better health, and reduced costs through improvement"¹ coupled with an innovation investment portfolio of several billion dollars. Other contemporary examples include the Patient-Centered Outcomes Research Institute (PCORI), a private organization created as part of health reform to promote and support comparative effectiveness research and patient-centered outcomes research, with a planned public and private annual funding stream of several hundred million dollars, plus a wide range of initiatives driven by private health plans, care providers, and employers.²

Concurrently, defining and deriving the "value" of health care services has become substantially more complex as the number and diversity of key stakeholders has expanded. Attempts to reconcile views of value are a mix of observed or projected analytics to create clarity (and, in some cases, even presumed "certainty") juxtaposed with major political debate and substantial disagreement about the key issues and goals that should be objectified.

Although data are increasingly abundant and research and analytic tools have become more sophisticated, it also has become clear that the scope of value determination as it has been practiced in

the past lacks generalizable application across the emerging concerns of the diverse set of stakeholders. More depth and dimension are needed to fully leverage the simple value equation of $V(\text{value})=Q(\text{quality})/C(\text{cost})$.

For a concept as complex as value, the evolution of its expanded meaning and application in measurement and prioritization of effort likely will require multiple incremental changes. The following 3 promising areas of important augmentation to the current derivation of "value" will be discussed and include:

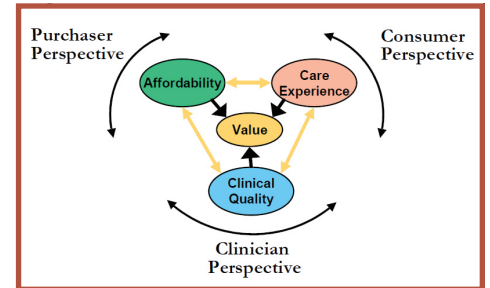
- The importance of reflecting and respecting multiple perspectives
- Appreciating what we don't know about the care experience, and
- Embracing that when there are multiple aims for improvement, you must address all concurrently.

The Importance of Perspective: "What Will it Take for the Patient and Payer to 'Get' Value?"

A few years ago at the Kaiser Permanente Care Management Institute, we systematically sought out and engaged groups of health system leaders, clinicians, patients, and payers to better understand how they perceived and evaluated "value" in health care. Initially, we wanted to know what would be required for the consumer/patient and employer/purchaser to understand "quality" and "value" as we perceived them from our perspective as managers of a large integrated delivery system. We saw value as best reflected by nested and explicitly defined measures of health care system structure, process, and health outcomes such as the Healthcare Effectiveness Data and Information Set Quality Indicators.³ However, the more complex value framework we eventually derived (Figure 1) reflected and, perhaps

more importantly, *respected* the differences between key perspectives.

Figure 1. A Model of Health Care Value



Source: Bellows J, Sullivan MP. *Could a quality index help us navigate the chasm?* http://xnnet.kp.org/ihp/publications/docs/quality_background.pdf. Accessed July 11, 2012.

Clinicians and health system leaders most frequently associated value with "traditional" metrics of clinical structure, process, and health outcomes whereas patients identified aspects of the care experience, such as convenience, respectful providers, and trusting relationships with their clinicians, as most critical for them in terms of engagement and as meaningful attributes of value.

Not surprisingly, organizations and entities that provide payment for services, including public payers, private health plans, and major employers, identified financial metrics - especially affordability plus return on their health-associated investments - as their leading indicators of value. Importantly, no payer suggested reducing costs by relaxing clinical quality standards. Rather, cost impact was generally identified as attainable through improved efficiency and reduction of waste. Each stakeholder's perspective recognized and granted importance to the elements valued by other stakeholder perspectives, albeit with lower priority. However, each stakeholder assigned prime "value" to substantially different metrics. Each stakeholder perspective did "get quality," but in its own manner.

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Other efforts also have addressed the impact of multiple perspectives on value perception and definition. A relatively encyclopedic consideration of the complexity of the challenge has recently been published by the Institute of Medicine.⁴

Appreciating What We Don't Know: The Complex Nature of the Care Experience

Although patient-centeredness has been positioned securely as a basic element of quality, and hence value, since the sentinel Institute of Medicine quality reports of the last 2 decades, measurement frameworks to robustly reflect and capture a patient's care experience have been problematic. Most recent progress has followed from the leadership of the Agency for Healthcare Research and Quality in developing and promoting standardized patient surveys such as the Consumer Assessment of Healthcare Providers and Systems family of instruments.⁵ Although the capability for doing such surveys is a significant achievement, additional complementary approaches to better bridge other forms of value-related measurement to the patient experience are needed. Today's patients increasingly have multiple clinicians, often receive care in multiple locations, are responsible for major portions of their care while at home, and have little cohesion across settings other than themselves and their families. Consequently there is a need to move beyond an exclusive focus on what can be done *to and for* patients *by* providers and a health system.

At a roundtable discussion of patient-centeredness among several California and national health care leaders, the successful patient experience was equated with enabling patients to understand, participate in, and direct their own care. Examples included shared decision making, use of personal health records by patients and their clinicians, and

programs for palliative and end-of-life care that require care decisions to be highly customized for, and dependent on, the patient and his or her family.⁶ Building from this discussion, a value measurement framework that is informative across the patient experience should ideally include metrics that reflect:

- Care delivered *for the patient* (eg, key prevention testing, case management, much of chronic condition management)
- Care delivered *with the patient*, (eg, shared decision making, care coordination)
- Care “delivered” *by the patient and his or her family*, ideally with health system support (eg, traditional self-care, health behavior change, much of end-of-life support).

In aggregate, a credible future value framework will need to both respect and reflect the varying loci of control for different aspects of the pursuit of health and delivery of health care.

The expanded national investment in the PCORI achieved as part of the ACA offers substantial leadership and funding to better understand how to engage and inform patients about their care and care experience.

Addressing One Dimension of Value at a Time Is Not Enough- The Integrating Message of Concurrent Aims

The value model in Figure 1 is a close analog of the Triple Aim proposed by the Institute for Healthcare Improvement (IHI) with its 3 overarching goals to be addressed in pursuit of improved health system value.⁷ The IHI specific aims are to:

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and

- Reduce, or at least control, the per capita cost of care.⁷

Very similar concepts – Better Care, Affordable Care, and Healthy People/Healthy Communities – now form the framework for the National Quality Strategy.⁸

The Triple Aim and National Quality Strategy share a common core concept: Meaningful and sustainable value realization requires focused and coordinated improvement addressing all of the main dimensions of value at the same time. It is insufficient to focus exclusively on a single dimension – whether it be cost, quality, or the care experience – and expect the other dimensions to fall into line. For example, a common refrain in recent years – “if quality is addressed then cost improvement will follow” – has led to initiatives that fail to identify and pursue explicit timelines for addressing cost issues. Quality, as observed by the usual measures, has arguably improved while an equivalent impact on cost has remained on a future “to follow.” Similarly, the cost-focused efforts of the 1990s failed to impact quality equally and adversely affected the care experience.

The learning embodied in the Triple Aim is that true progress toward higher value health care requires progress in multiple dimensions simultaneously, with leadership and provider focus on managing and reconciling the inevitable conflicts and ambiguities inherent in having goals embedded in such a complex framework. As a hopeful sign, a growing number of organizations are now simultaneously achieving improvement across these multiple determinants of value. Common traits across the diverse mix of payers and providers achieving cross-cutting improvement include:

- Balance of system-based and individual changes.
- New ways to engage both providers and patients.
- Focus on population care.
- Use of health information technology.

Recently, others have provided guidance about how to effectively focus evaluations to gauge the full return on these investments.⁹ The most useful evaluations will be those that:

- Focus on change that matters.
- Document innovations to support effective learning and dissemination.
- Balance flexibility and speed with rigor in developing evidence to support policy change.

Summary

As efforts to reform health care financing and delivery intensify and come under increased scrutiny by varied stakeholders, gradual but significant progress is being made in evolving a durable and

sustainable framework for measuring value. Key aspects of this emerging framework are respect for varying perspectives of value and substantial investments in better understanding and characterizing all dimensions of value – those most directly reflecting the care experience in particular. A hopeful sign is that a growing number of organizations are achieving concurrent improvements in multiple aspects of quality, cost, and the patient care experience, and the attributes and practices of these leading groups are being successfully characterized and spread.

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A Black Swan Comes to Philadelphia

By Jeffrey Brenner, MD

Have you ever wondered how the US health care landscape will evolve if, as some prefer, the system is not subjected to reforms and warnings about the consequences are ignored? I have, and I fear that by 2017 we might open our newspapers to read real stories like this one.

Philadelphia Inquirer
3/20/2017

The President and CEO of Hamilton University Hospital emerged today after marathon discussions about the future of the organization with an announcement

on the imminent closure of the 200-year-old hospital.

Accompanied by the mayor, he spoke to the large crowd of employees and local Philadelphia leaders.

“We’ve done everything we can,” he said. “We’ll be shutting down by the end of the month. I expect an orderly and safe process to ensure that every patient receives the highest quality of care until the last day.”

The mayor said, “The bondholders have spoken and we are out of options. There are no more bailouts coming for our city’s hospitals.”

Hamilton will be the tenth academic health center in a major US city to close this year.

When asked about the growing trend, a Brookings Institute health policy expert said, “After a series of bailouts by the federal government, the public appetite for rescuing hospitals has diminished.”

In 2015, twenty-five large academic health centers received federal loans through a still controversial Presidential decision – a rescue package totaling over \$75 billion. None of the loans are expected to be repaid because the financial condition of the hospitals has worsened.

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An American Association of Retired Persons spokesperson asked, “How can we justify spending more precious Medicare dollars on bailing out hospitals when Medicare patients can’t find a primary care provider to take care of them? Waiting lists in cities like Philadelphia have grown into the thousands for the average practice.”

A major bondholder for the hospital is expected to lose over \$350 million in the closure of Hamilton University Hospital. When asked about this significant financial loss, its president said, “Events like this are not predictable. Along with the new management team at the hospital, we did the best we could to turn this around over the past year. But with changes in federal funding there was no way to make this work.”

The last few years have seen dramatic reductions in National Institutes of Health research spending, Medicare reimbursements, and pharmaceutical industry sponsorships, pushing many academic health centers in the US to the brink of bankruptcy. Most government budget experts cite the unexpected attack on American cities by foreign eco-terrorists, angry over rising sea levels, for the current financial crisis in health care.

A well-known economist noted, “The US economy was already in a weakened state after years of unemployment, economic stagnation, and political paralysis before the attacks. Also, we just weren’t ready for the tsunami of aging baby boomers. How could we have known the number of new expensive treatments that would come to the marketplace?”

Struggling foreign relations haven’t helped either, he added: “When the Chinese stopped buying our bonds, it really closed the door on our ability to keep bailing out hospitals in the US.”

When a world famous but terminally ill rock legend walked out of the ICU at a leading New York hospital in 2014, declaring that he would never die in a hospital, he began a trend among baby boomers that has spread quickly. The growing natural death movement has had an unexpected impact on the censuses in American hospital ICUs.

One plan for the rescue of Hamilton Hospital had been a buyout from a large health insurance conglomerate. A spokesperson for the company said in a statement today, “We’ve bought over 20 academic health centers this year, but the marketplace in Philadelphia is too overcrowded. We couldn’t see a pathway to profitability for this deal.”

Some experts say the nation has not seen this level of hospital closures since the 1950s and 1960s, when financial pressures forced states to shut psychiatric hospitals in droves.

“Look what a mess we made when waves of mentally ill patients were released from psychiatric hospitals and overran urban communities without adequate outpatient services,” said a prominent US history professor. “We are similarly unprepared for the consequences of deinstitutionalizing medical care in our country today.”

The closure of Hamilton Hospital is expected to have painful consequences for a city already reeling from record unemployment, falling housing prices, and significant reductions in student enrollment at the city’s flagship educational institution.

“The Eds and Meds model is over,” said a spokesperson for Philadelphia’s business community. “Philadelphia needs to find a new economic driver.”

At today’s press conference, nurses said they offered concessions to keep Hamilton open. “We made significant offers for voluntary cuts to our wages and benefits. We did our part but it wasn’t enough to save the hospital.”

In the last 4 years many nurses across the US have shifted from working in hospitals to home-based care.

Standing in front of Hamilton Hospital as the announcement was made were hundreds of residents and interns dressed in white coats and scrubs. They looked shocked as they realized their training programs would be disbanded.

A fourth-year surgery resident said, “All of us have over \$400,000 in loans. If we can’t finish our training how will we ever pay off this debt? With the increasing number of hospital closures across the country, there are no more residency slots available. Now I might be headed abroad to finish my training.”

A growing number of hospitals in foreign countries have begun to recruit American medical school graduates and trainees to complete their training. With the closure of places like Hamilton Hospital this trend is expected to accelerate.

The “news item” might go on, but the message should already be clear. Without willingness to recognize these enormous problems and their consequences – and without a collective commitment to change – it is certainly possible that we will be faced with this type of scenario in the not-too-distant future.

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