

The Future of Health Care in Alaska

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- We cannot talk about the future of health care without consideration of current health care economic realities

The Cost of Health Care

A personal economic issue

A governmental economic issue

An American economic issue (perhaps our
greatest economic issue)

An international economic competitiveness issue

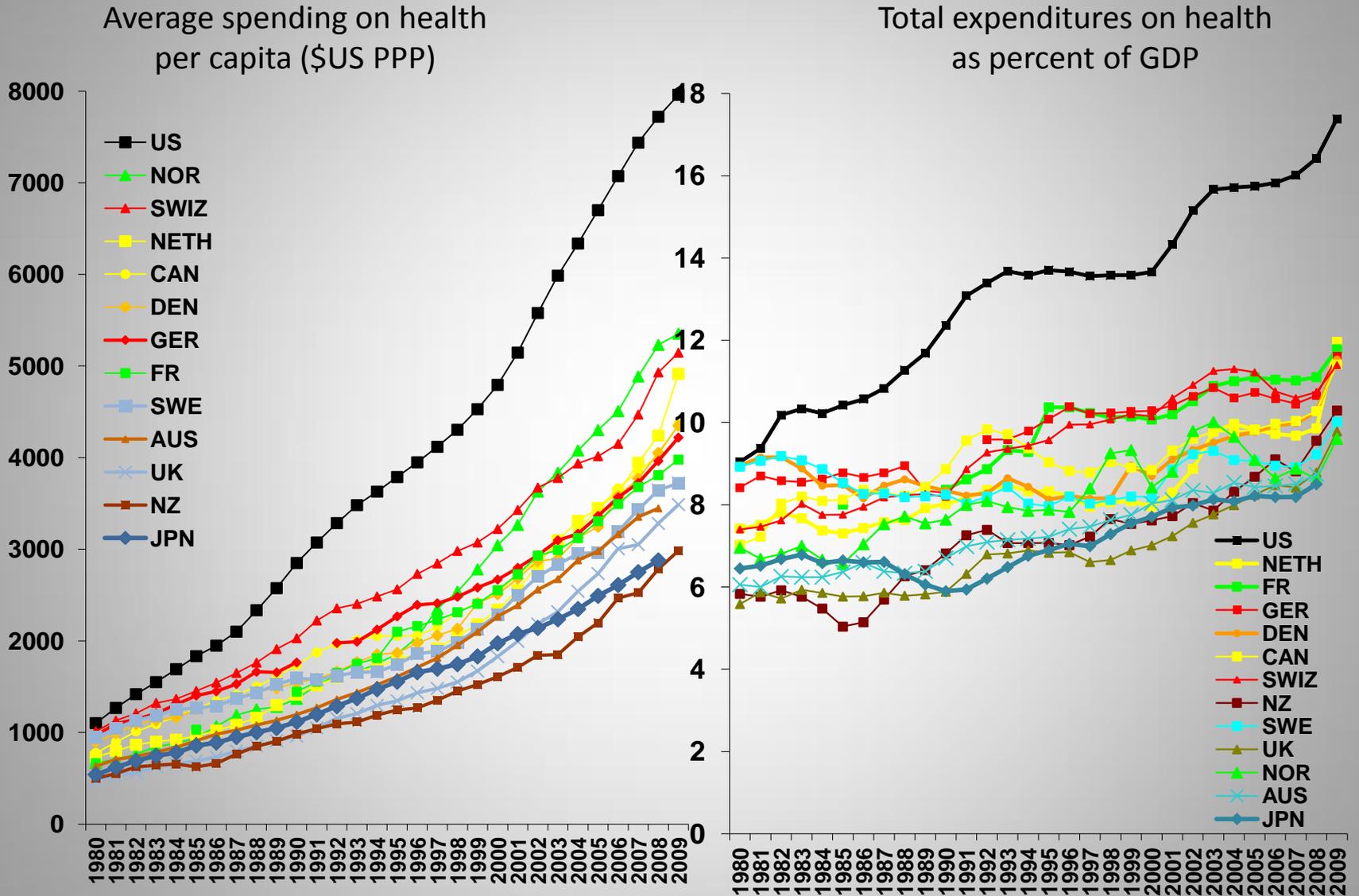
A moral issue (because of trade-offs)

Healthcare Costs in the USA

- During 2012 healthcare costs in the USA will be about \$2.75 trillion
- For 310 million people that is almost \$9,000 per person

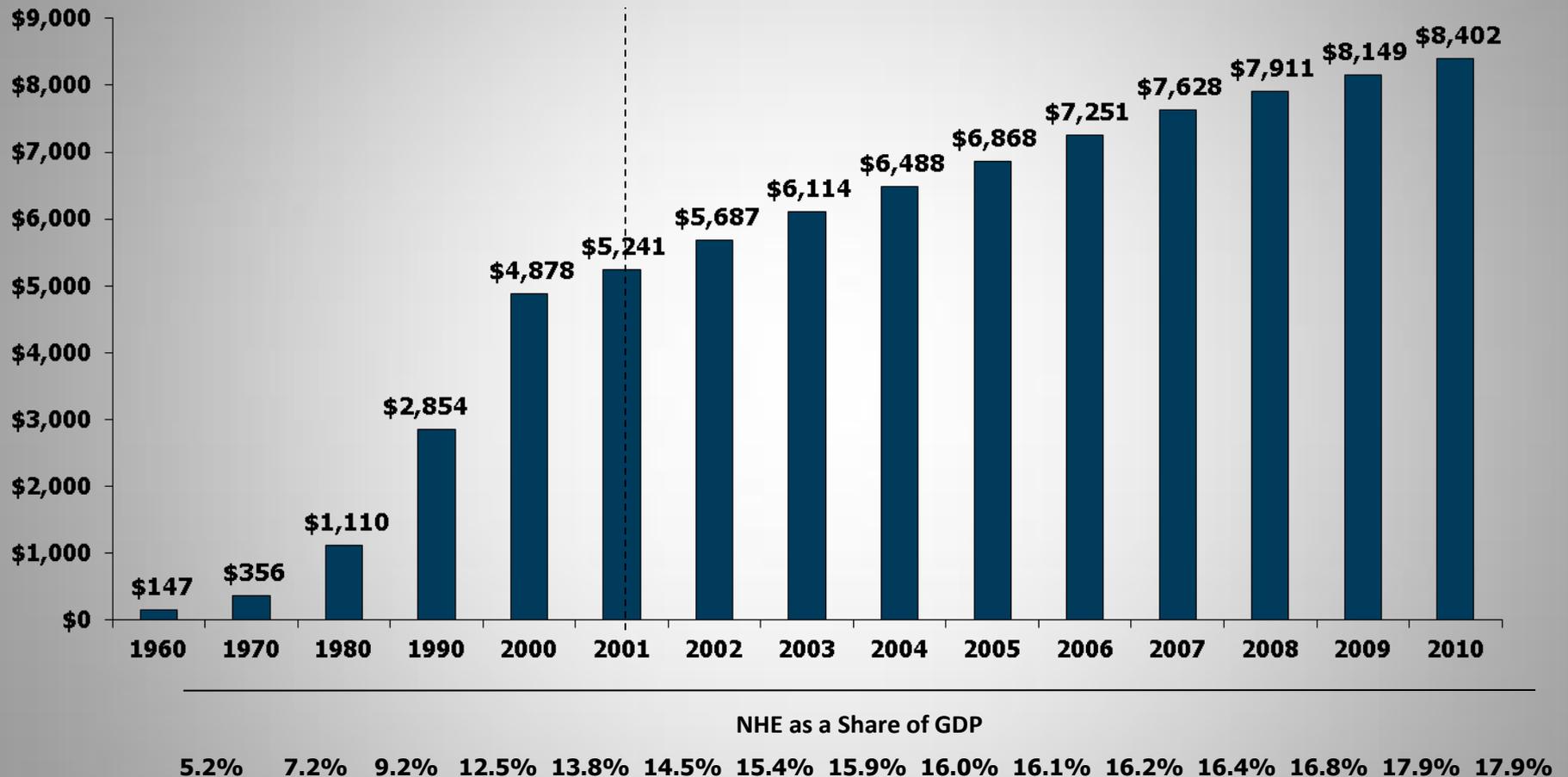
How do USA expenditures on healthcare compare to other industrialized countries?

Exhibit 1. International Comparison of Spending on Health, 1980–2009



Note: PPP = Purchasing power parity—an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the prices of goods and services in the countries concerned.
 Source: OECD Health Data 2011 (Nov. 2011).

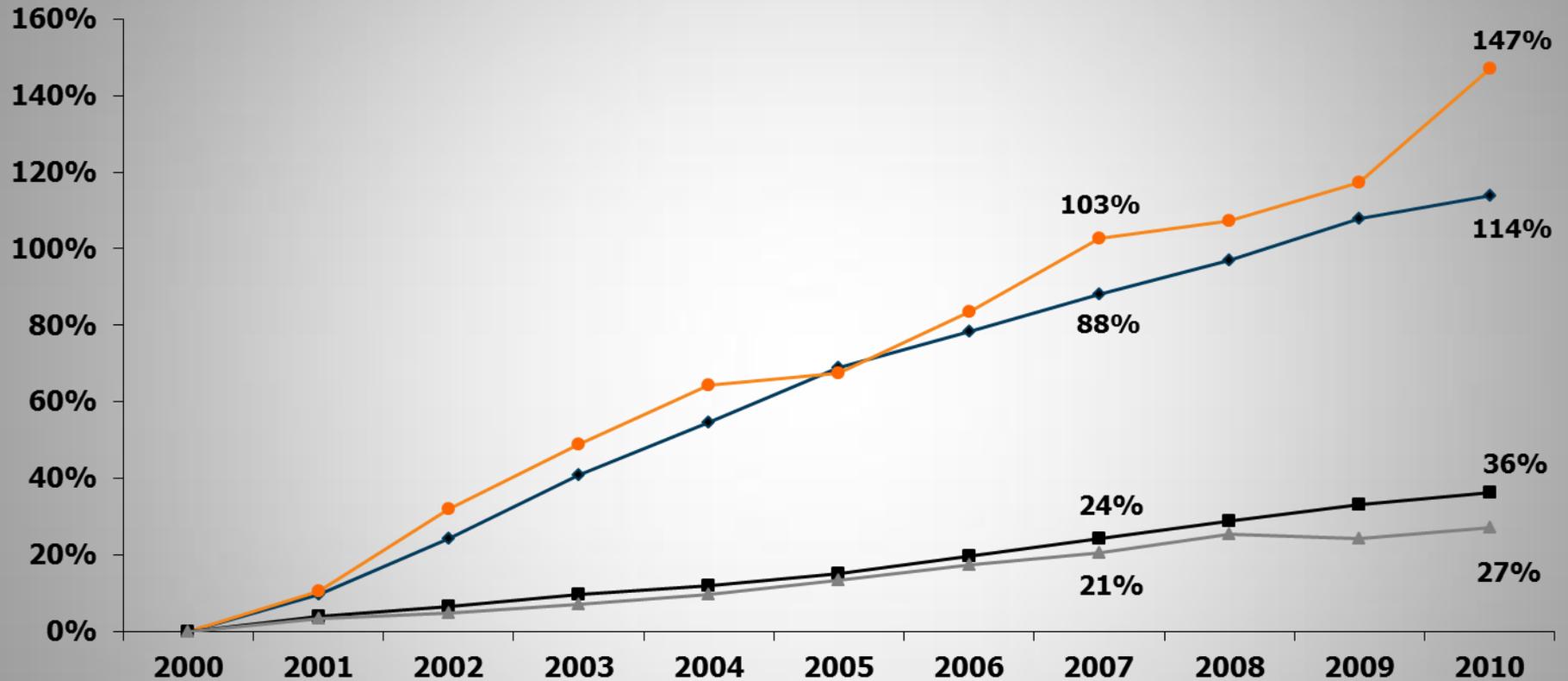
National Health Expenditures per Capita, 1960-2010



Notes: According to CMS, population is the U.S. Bureau of the Census resident-based population, less armed forces overseas and population of outlying areas, plus the net undercount.

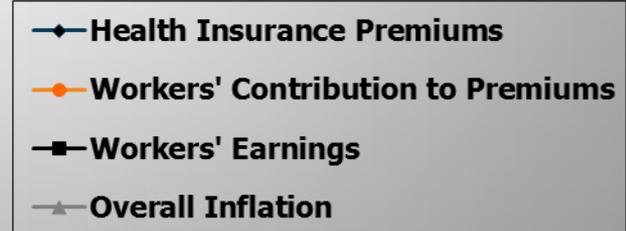
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; NHE summary including share of GDP, CY 1960-2010; file nhegdp10.zip).

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 2000-2010



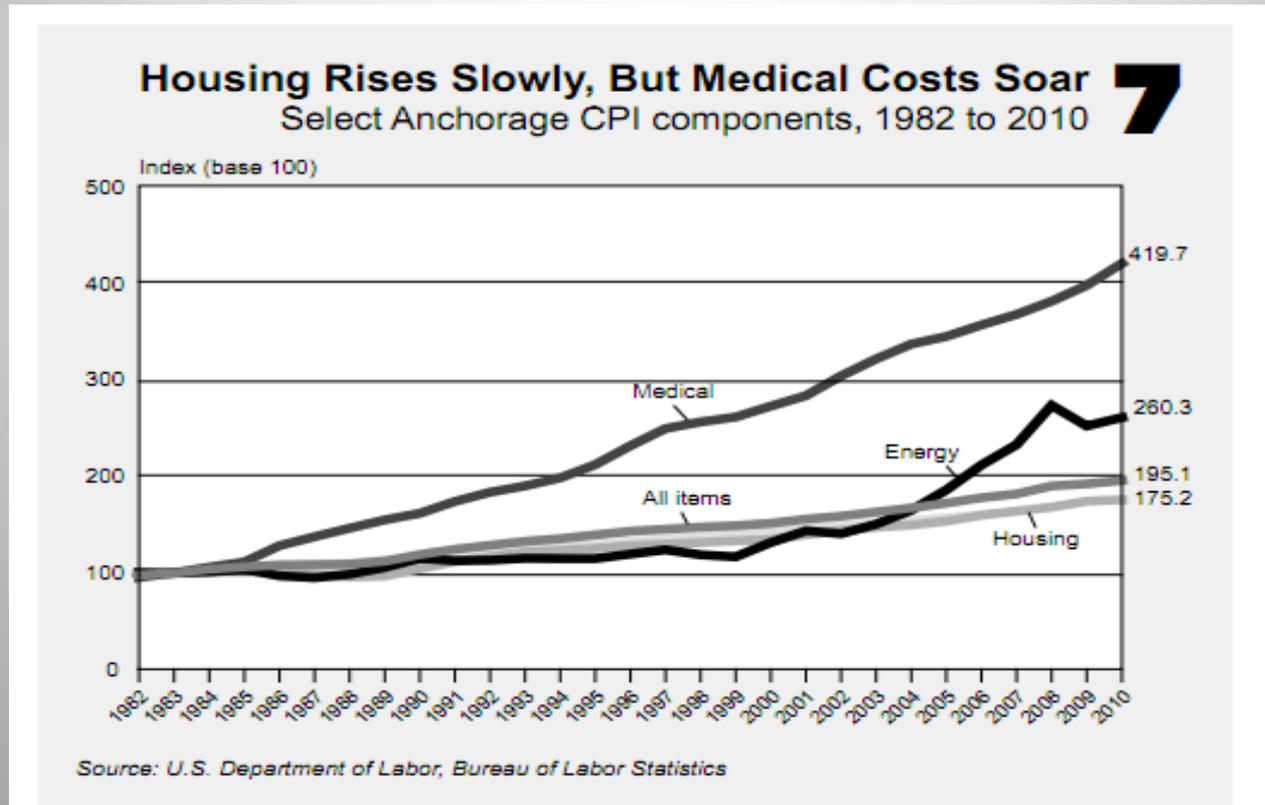
Notes: Health insurance premiums and worker contributions are for family premiums based on a family of four.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2011. Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2011 (April to April).



Housing Rises Slowly But Medical Costs Soar

- During the past decade, medical costs in Anchorage increased by 46% compared to 27% nationwide



The Washington Post

- “By 2037, health insurance will swallow your entire paycheck”
3/14/12
 - If health insurance premiums and national wages continue to grow at recent rates and the US Health system makes no major structural changes, the average cost of a family health insurance premium will equal 50% of the household income by the year 2021 and surpass the average household income by the year 2033. If out of pocket costs are added the 50% threshold is crossed by 2018 and exceeds household income by 2030

The Washington Post

- “Health care costs are driving people into poverty” 12/6/11
- “High health care costs: It’s all in the pricing”
 - “In 2009, Americans spent \$7960 per person on health care. Our neighbors in Canada spent \$4,808. The Germans spent \$4,218. The French, \$3,978. If we had the per person costs of any of those countries America’s deficits would vanish”.
3/2/12

Comparative Health Outcomes

United States

- Infant mortality 6.8 per 1000 live births
- Average life expectancy 77 years
- Even after reaching age 65 in the USA we don't live as long

Other Industrialized Countries

- Switzerland 4.2
- Japan 2.8
- Switzerland 81.3
- UK and Germany 79
- Japan 82.1

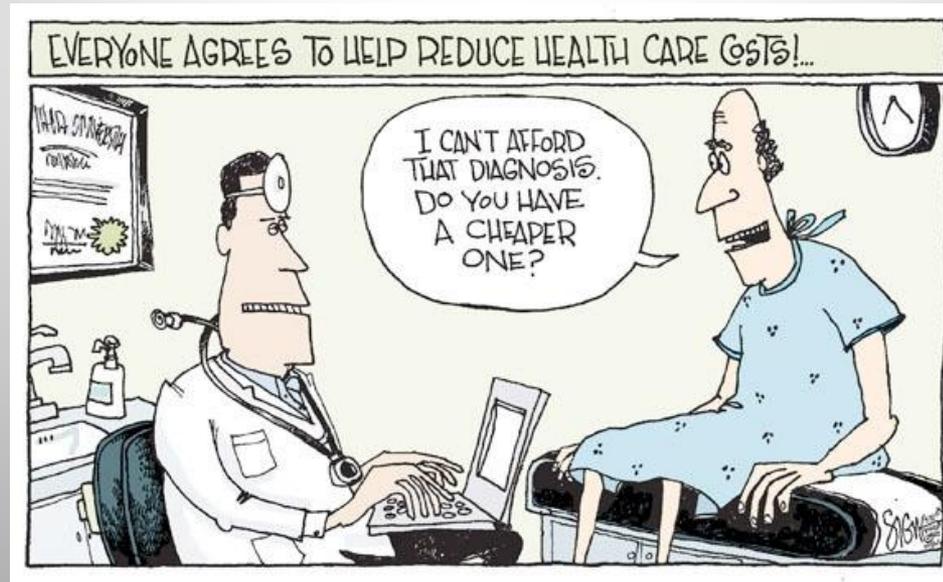
A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains For An Average US Family

- Over a decade, the median income family of four with health insurance from their employer saw their real annual earnings rise from \$76,000 in 1999 to \$99,000 in 2009. But nearly all that gain was eaten up by rising health care costs.

Source – Health Affairs, September 2011 30:9

Alaska

- Total private sector (for profit and non-profit) wages and benefits about \$12.5 billion
- Medical care costs in Alaska exceed \$8 billion annually



Alaska's (America's) Cost of Health Care is Not Sustainable

- We cannot reasonably expect nor responsibly ask for additional resources – even based on a sincerely believed promise that “we can save money in the long run”.
- Not a piece of a “bigger pie” to invest in the medical offset for behavioral health services.
- Not a piece of a “bigger pie” to invest in the patient centered medical home.

Alaska's (America's) Cost of Health Care is Not Sustainable

- In the long run to remain economically competitive America needs to reduce what we spend on health care as a per cent of our GDP.
- In the short run we spend a great deal of money on health care
- Value-adding process businesses “take in incomplete or broken things and then transform them into more complete outputs of higher value”. (The Innovator's Prescription: A Disruptive Solution for Health Care – C Christensen et al)

Alaska's (America's) Cost of Health Care is Not Sustainable

- Evidence based decision making
 - “As the results came in we found extensive and seemingly inexplicable variation in the ways health care was delivered from one Vermont community to another”. (Tracking Medicine: A researcher's Quest to Understand health Care – John Wennberg)
 - “Indeed if the nation were able to bring care intensity down to the per capita benchmarks provided by such low rate regions savings of up to 40% could be realized”. (Ibid)

Why Are Health Care Costs High Everywhere? Are There Opportunities?

- Practice variation and comparative effectiveness
– John Wennberg and Atul Gawande

	<i>Middlebury, Vermont</i>	<i>Randolph, New Hampshire</i>
<i>Socioeconomic characteristics</i>	Matched	
<i>Chronic illness level</i>		
Prevalance	23%	23%
Restricted activity last 2 weeks	5	4
More than 2 weeks in bed last year	4	5
<i>Access to physician</i>		
Contact with physician within year	73%	73%
<i>"Post access" utilization of health care</i>		
Hospital discharges per 1,000	132	220
Surgery discharges per 1,000	49	80
Medicare Part B spending per Enrollee (\$)	92	142

Source – Journal of the Maine Medical Association 68(8) (1977)

Alaska's (America's) Cost of Health Care is Not Sustainable

- Comparative effectiveness research
 - How Medicaid Could Use Comparative Effectiveness Research in Deciding on New Coverage and Reimbursement
 - Health Affairs 10/10
 - Paying equally for comparable results is a powerful principle.
 - This is not about saying “no”. It is about saying “yes and we will pay you more” or “yes and we will pay you the same” or “yes and we will give you the benefit of the doubt for (three years) to stimulate innovation”.

Real Life

- Revlimid has been approved by the FDA for relapsing multiple myeloma
 - Revlimid costs \$10,000 a month and is given monthly
 - Revlimid plus methotrexate results in average survival for these patients of more than 29 months
 - Methotrexate alone results in average survival for these patients of more than 20 months
 - Nine months added survival for average cost of an additional \$290,000 plus administration fees

Real Life

- Rheumatoid arthritis – a common diagnosis
 - Treatments include NSAIDs, patient education, pain management, low dose glucocorticoids, DMARDs, and the newer biologic drugs – increasing order of cost
 - Concept of QALY (Quality Adjusted Life Year)
 - Addition of DMARD (methotrexate) cost \$4,849 per QALY
 - Addition of biologic agent (e.g. Humira – adalimumab or Embrel – etanercept) costs \$157,350 per QALY (Annals of Internal Medicine)

Categories of recommendations

US Preventive Services Task Force

- Level A: Good scientific evidence suggest that the benefits of the clinical services substantially outweighs the potential risks. Clinicians should discuss the service with eligible patients.
- Level B: At least fair scientific evidence suggests that the benefits of the clinical service outweighs the potential risks. Clinicians should discuss the service with eligible patients.
- Level C: At least fair scientific evidence suggests that there are benefits provided by the clinical service, but the balance between benefits and risks are too close for making general recommendations. Clinicians need not offer it unless there are individual considerations.

Categories of recommendations

US Preventive Services Task Force

Continued

- Level D: At least fair scientific evidence suggests that the risks of the clinical service outweighs potential benefits. Clinicians should not routinely offer the service to patients
- Level I: Scientific evidence is lacking, of poor quality, or conflicting, such that the risk versus benefit balance cannot be assessed. Clinicians should help patients understand the uncertainty surrounding the clinical service

Recommendations Paraphrased

Courtesy Neil Calonge, MD, Chair US Preventive Services Task Force

- Base decisions on evidence of effectiveness and benefit
 - When there is evidence of benefit, **do it**
 - When there is evidence of no benefit or harm, **don't do it**
 - When there is insufficient evidence to determine if there is benefit, be conservative: **use individual discretion, but if there are harms or costs, don't do it.**

Integration of Health Care

- Objectives are to improve quality, effectiveness, and efficiency (cost issue)
- Subspecialization has led to both awesome gains (e.g. retinal surgery) and some losses (e.g. otolaryngologists don't do pap smears)
- Behavioral health needs are frequently recognized by primary care providers but are then often overlooked or not pursued.
- Behavioral health providers often perceive that medical providers do not appreciate the reality of the benefit of the “medical offset”.

Examples of Successful Efforts Toward Integration

- SCF Nuka Model clinic
- Group Health PCMH
- Molina and Compass Health in Snohomish County
- British Columbia enhancement of provider's capability

A Few Examples

- ACEs Study and its broad implications
- End of life care (1 – 2% of GDP)
- Illicit use of opioids now leads to more deaths than motor vehicle accidents
 - Alaska's rate of prescription drug overdoses is more than twice that of the US overall
- Challenges of domestic violence and abuse and Governor Parnell's priority

Closing Comments

- There is a growing understanding of the value of and need for more integration of behavioral health and medical care.
- All of us in our broad industry need to subject ourselves to an understanding of and use of evidence based decision making – in the clinical setting and in benefit coverage decisions.
 - “It is difficult to get a man to understand something when his salary depends on him not understanding it”. (Upton Sinclair)

Your comments or questions

Ward B. Hurlburt, M.D. , MPH
Chief Medical Officer
Alaska Department of Health and Social Services
December 13, 2012

ward.hurlburt@alaska.gov