
INHEALTH
FIFTH ANNIVERSARY
INSTITUTE FOR HEALTH® TECHNOLOGY STUDIES
2010 HEALTH TECHNOLOGY SUMMIT
Medtech in the
New Healthcare Economy
Risk or Reward?
April 7, 2010 • Grand Hyatt, Washington, DC

Medtech Innovation in a Reformed Delivery System

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MEDTECH INNOVATION IN A REFORMED DELIVERY SYSTEM

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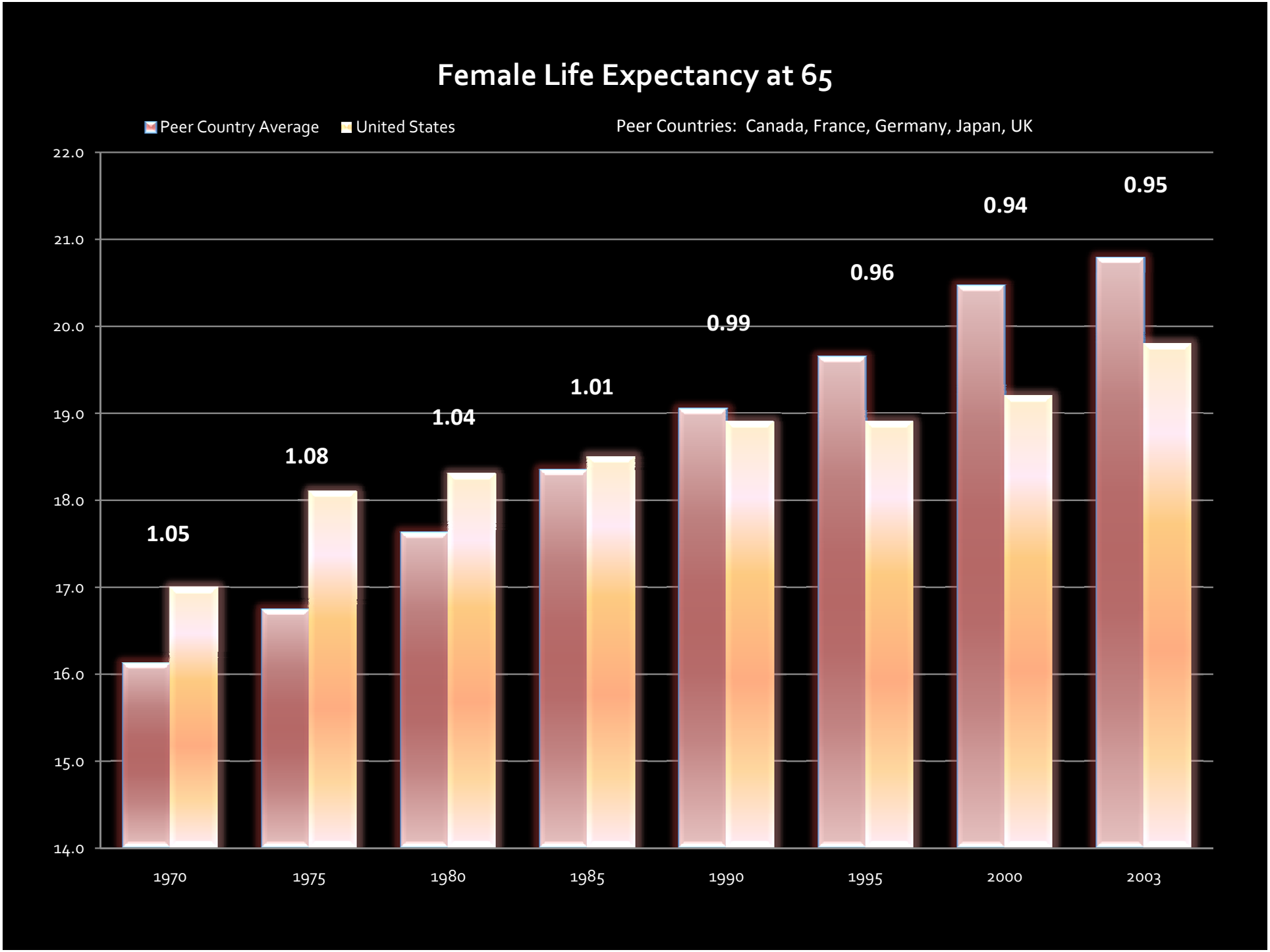
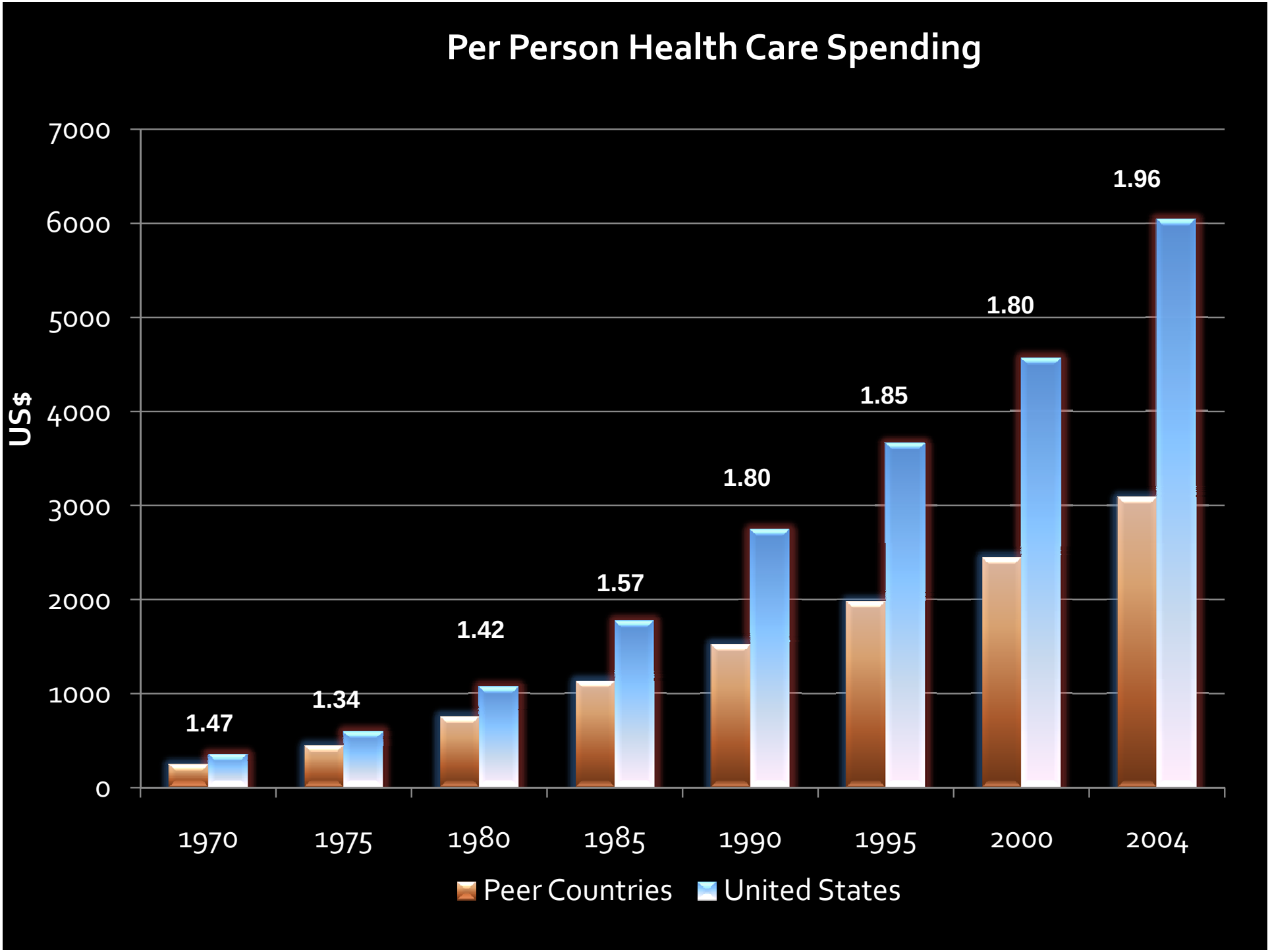
The policy context: Should we be concerned about rising health expenditures?

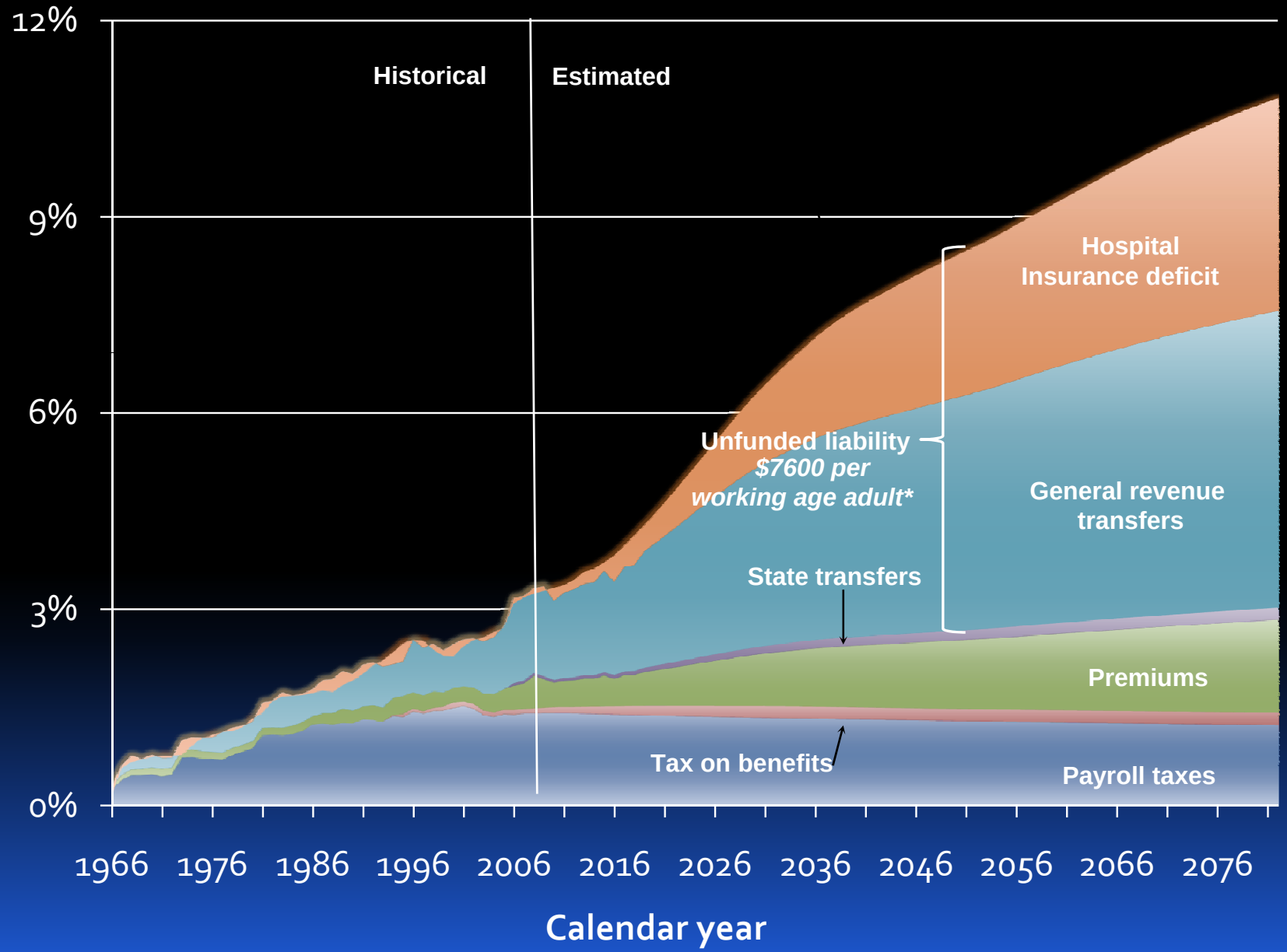
According to economists,

- Value of increased longevity since 1970 worth $95 trillion (3x health spending)
- Improvements in health highly cost-effective


Female Life Expectancy at 65
Peer Country Average
United States
Peer Countries: Canada, France, Germany, Japan, UK
22.0
21.0
20.0
19.0
18.0
17.0
16.0
15.0
14.0
1.05
1.08
1.04
1.01
0.99
0.96
0.94
0.95
1970
1975
1980
1985
1990
1995
2000
2003


Per Person Health Care Spending
US$
7000
6000
5000
4000
3000
2000
1000
0
1.47
1.34
1.42
1.57
1.80
1.85
1.80
1.96
1970
1975
1980
1985
1990
1995
2000
2004
Peer Countries
United States

Medicare sources of non-interest income and expenditures as a percentage of Gross Domestic Product



*In constant 2008 dollars

Source: Office of the Actuary, CMS; 2008 Medicare Trustees Report

Health reform has upped the ante

CBO estimates of new expenditures for 2010-2019:

Insurance exchanges/subsidies: $358 billion

Reinsurance/risk adjustment: $106 billion

Medicaid/SCHIP: $434 billion

Revenues/cost offsets

$455 billion reduction Medicare/Medicaid/DSH

$107 billion fees on manufacturers and insurers

$210 billion increase in hospital insurance tax

Reform laws will reduce federal budget deficit

CBO: $124 billion net reduction in deficit 2010-2019 ($143 billion with education provisions)

Changing health care delivery and payment

- Providers given more financial responsibility
- Access to better information about provider quality
- Ultimate goal: promote better health outcomes, not higher volume of services

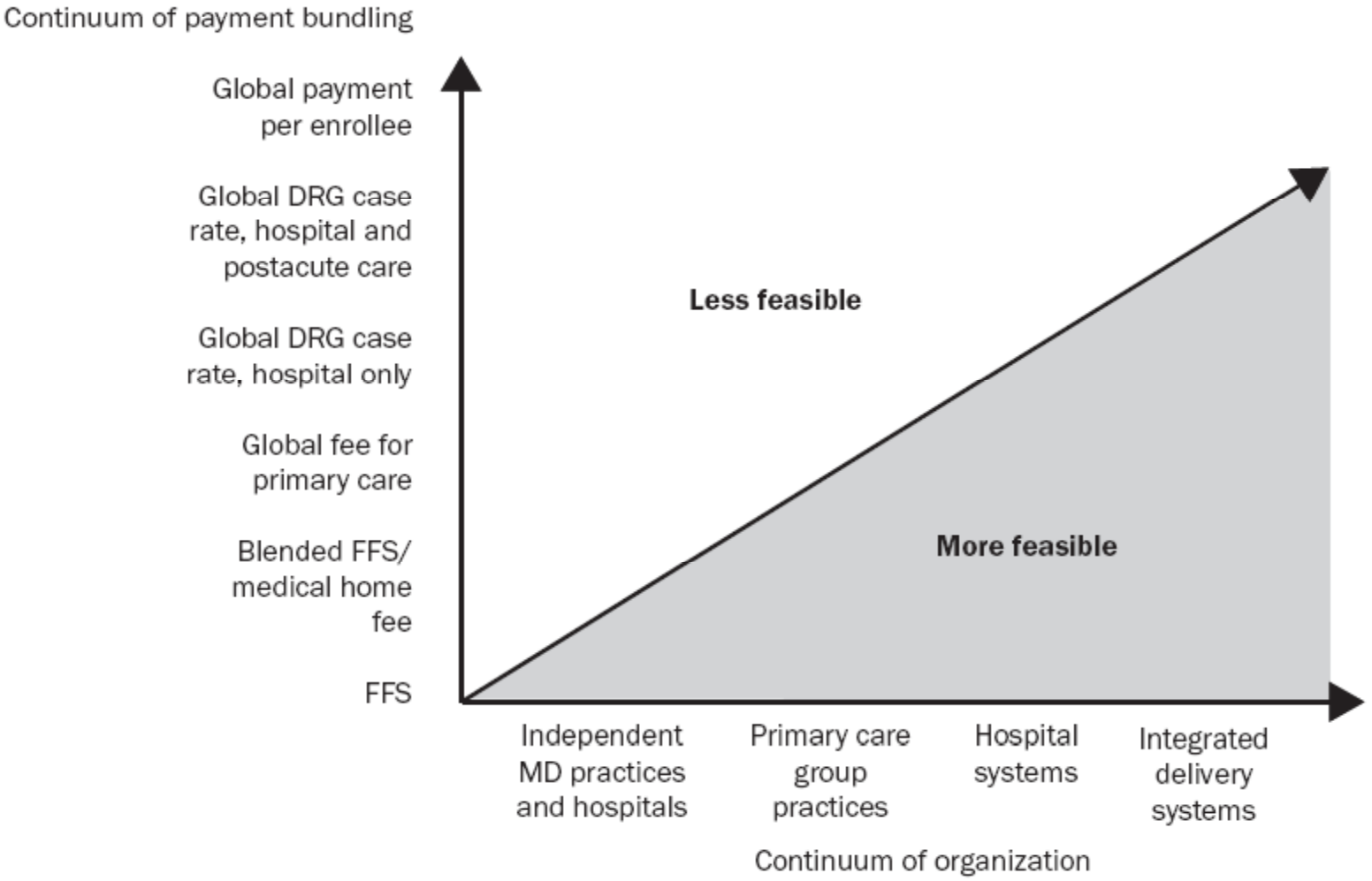
Health insurance exchanges

- Health plans compete on cost and quality, potentially on networks
- Insurance reforms to make it easier for individuals to purchase health insurance at more favorable rates
- Measures to control adverse selection

Changing payment mechanisms

- Center for Medicare and Medicaid Innovation
- Medicare Shared Savings Program
- National Pilot Program on Payment Bundling
- Hospital Readmissions Reduction Program
- Community-Based Care Transitions Demonstration
- Gainsharing Demonstration extension
- Independent Payment Advisory Board

Medicare Payment Reform Framework: Organization And Payment Methods



SOURCE: Authors' analysis.
NOTES: DRG is diagnosis-related group. FFS is fee-for-service.

Guterman S, Davis K, Schoenbaum S, Shih A, Health Aff (Millwood). 2009 Mar-Apr;28(2):w238-50. Epub 2009 Jan 2.

Comparative effectiveness research

- Ongoing commitment to research to study the outcomes that result from alternative approaches to care
- Look at specific treatments, but also patterns of care and benefit design

I believe that the information from comparative clinical effectiveness needs to be paired with financial incentives to encourage their more appropriate use… What that means is that when there is good clinical evidence… for treating a particular type of cardiac disease or orthopedic disease or whatever, you ought to have the lowest copayments… and higher copayments when the likelihood (of a positive outcome) is very uncertain or very low.

Gail Wilensky, former HCFA Administrator, June 4, 2009

Geisinger Approach

Our cardiology service line reviewed the American Heart Association and the American College of Cardiology guidelines for cardiac surgery and translated these into 40 verifiable best practice steps that we could implement with each patient undergoing this surgery. We hardwired these into our electronic health record so that we would be prompted to meet each identified step – or document the specific reason for any exception.

We then established a package price that included costs of the first physician visit when surgery was deemed necessary, all hospital costs for the surgery, and related care for 90-days after surgery, including cardiac rehabilitation.

Glenn Steele, testimony to Committee on Finance, U.S. Senate, April 21, 2009

Potential savings from CER

- Lewin Group : $18 billion first year, $368 billion over 10 years

Prevention and disease management: save more than $493 billion over 10 years (Lewin Group)

Capping the tax exclusion for health insurance

- Two effects:
  - increase federal revenue
  - promote lower-cost health insurance plans
- Revenue generated depends on level of cap and changes in markets for health insurance

Effects of taxing high-cost plans

In reaction to the tax, many employers would reduce the scope of their health benefits. The resulting reductions in covered services and/or increases in employee cost sharing requirements would induce workers to use fewer services…over time additional plans would become subject to the excise tax, prompting those employers to scale back coverage. This continuing cycle would have a moderate impact on the overall growth of expenditures for employer-sponsored plans.

Richard Foster, Chief Actuary, CMS, Dec 10, 2009

Additional sources of savings

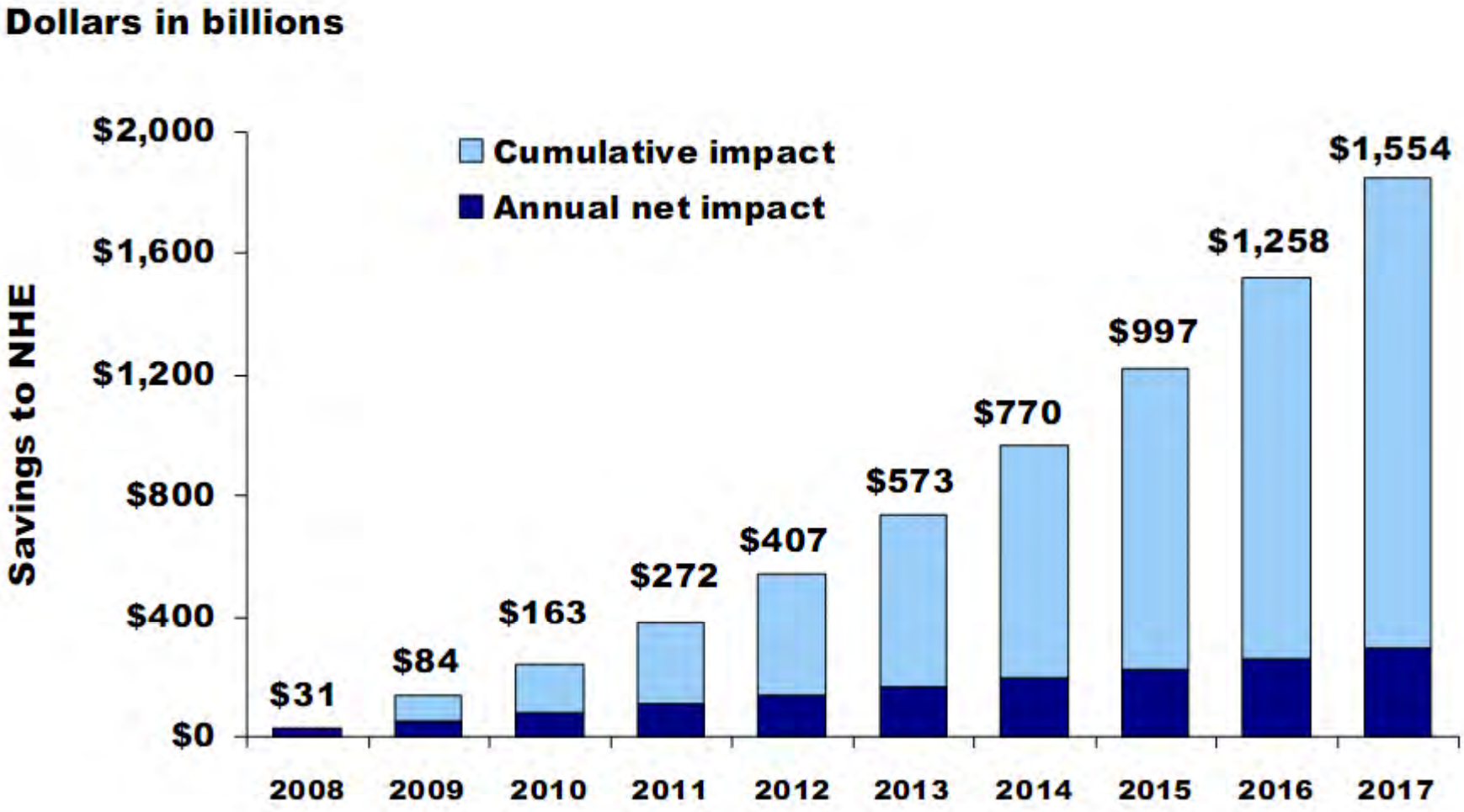
Producing and Using Better Information			
1. Promoting Health Information Technology	$8	$14	–$88
2. Center for Medical Effectiveness and Health Care Decision-Making	–$18	–$125	–$368
3. Patient Shared Decision-Making	–$1	–$4	–$9

Aligning Incentives with Quality and Efficiency			
7. Hospital Pay-for-Performance	–$2	–$14	–$34
8. Episode-of-Care Payment	–$17	–$96	–$229
9. Strengthening Primary Care and Care Coordination	–$5	–$60	–$194
10. Limit Federal Tax Exemptions for Premium Contributions	–$10	–$55	–$131

Numbers in billions of US $

Lewin Associates calculations, in Bending the Curve, Commonwealth Fund Commission on a High Performance Health System, Dec. 2007

Exhibit ES-4. Cumulative Impact on National Health Expenditures (NHE) of Insurance Connector Approach Plus Selected Individual Options



Note: Selected individual options include improved information, payment reform, and public health.
Source: Based on projected expenditures absent policy change and Lewin estimates.

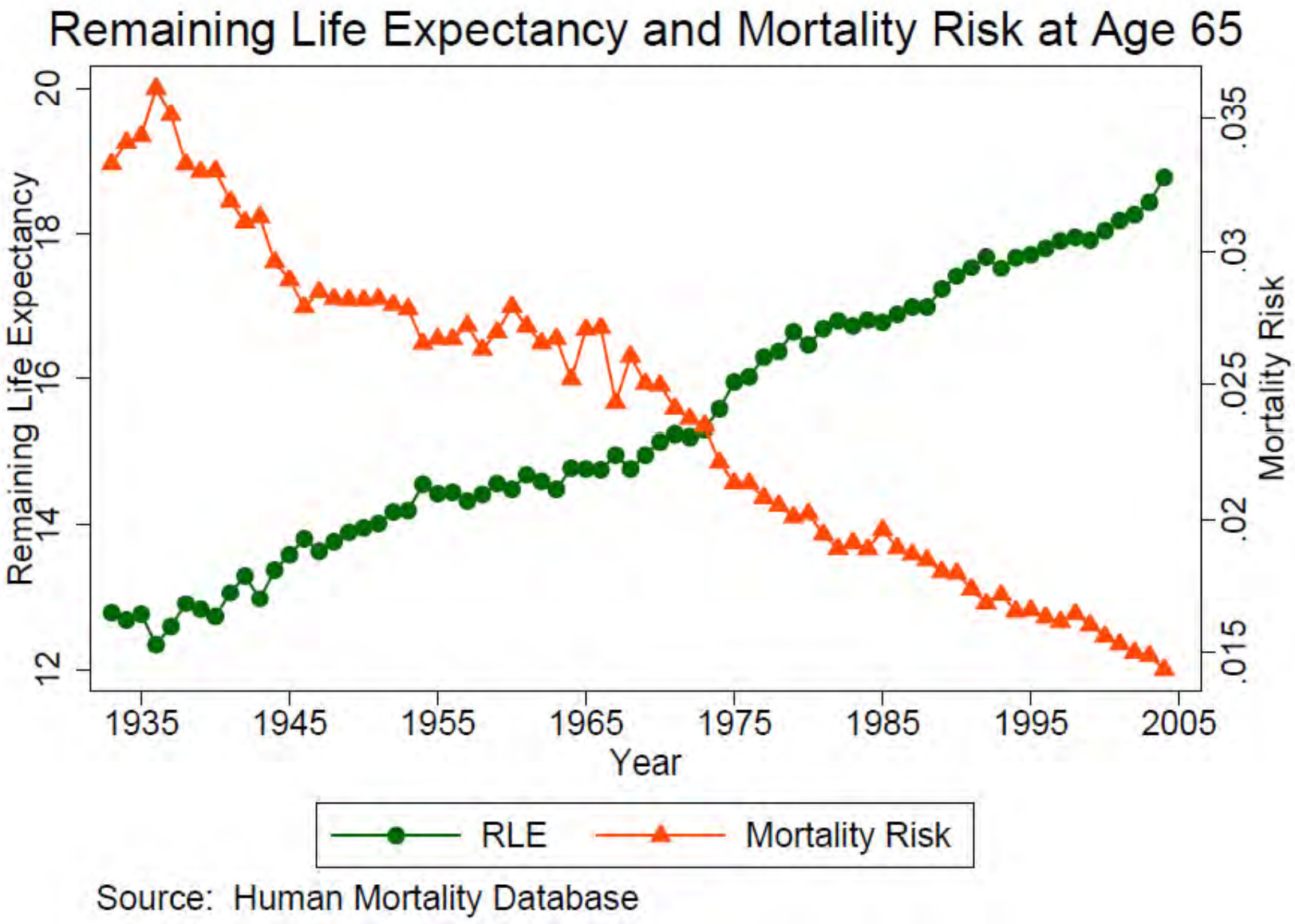
Reform implications

- Payment overhaul for both private insurance and Medicare
- Provider integration: Physicians, hospitals, other care providers who can work together will handle payment changes and quality requirements better – driven by private plans
- Other regulatory changes in private health insurance markets

What reform means for medtech

- Pressures to limit total costs of care
- Physicians, hospitals will bear more financial risk
- New pricing models may be attractive
- Some of the most interesting opportunities may seem to have little to do with health reform

Game-changing policy: Keep aging Americans healthy longer



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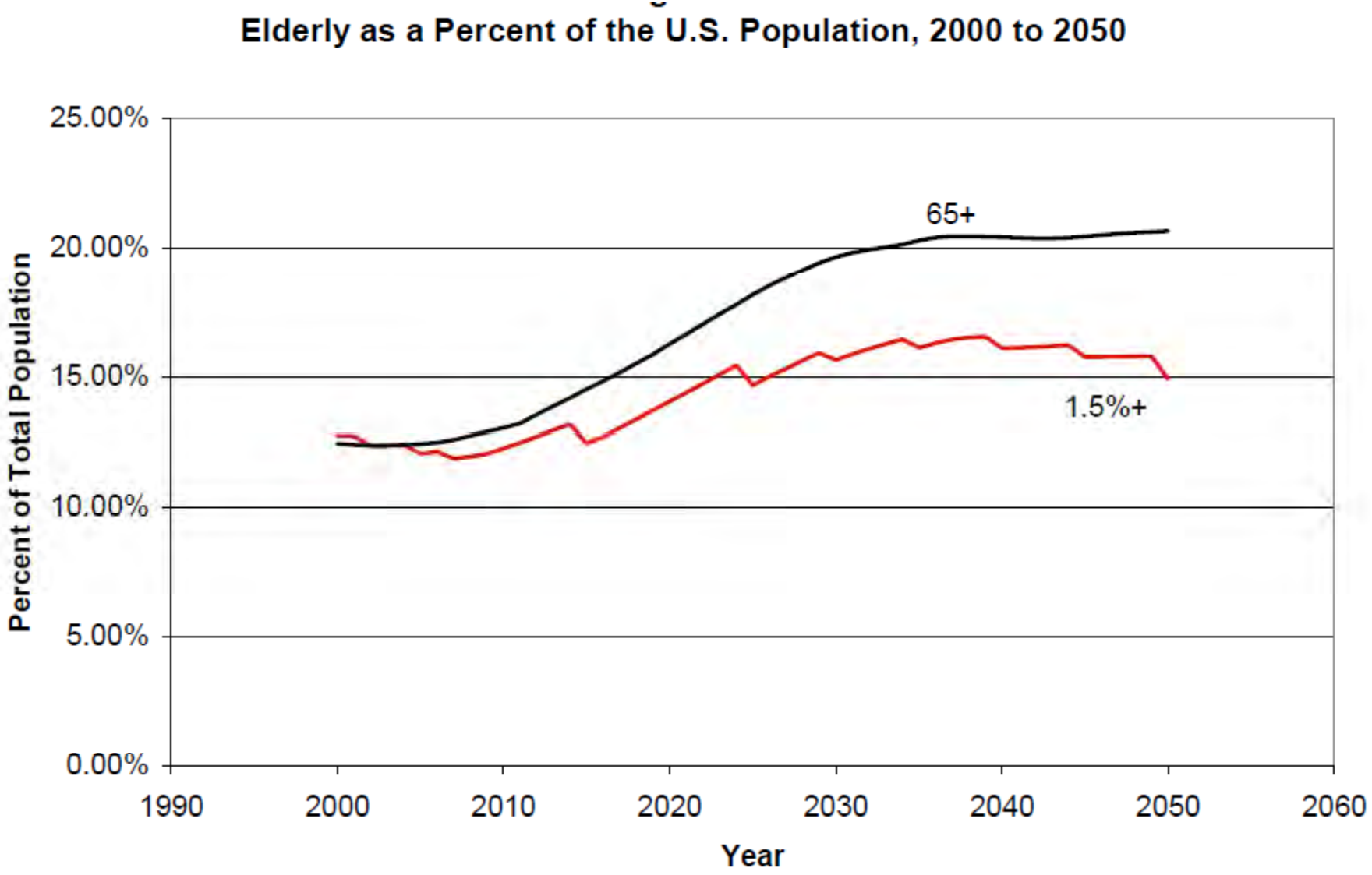

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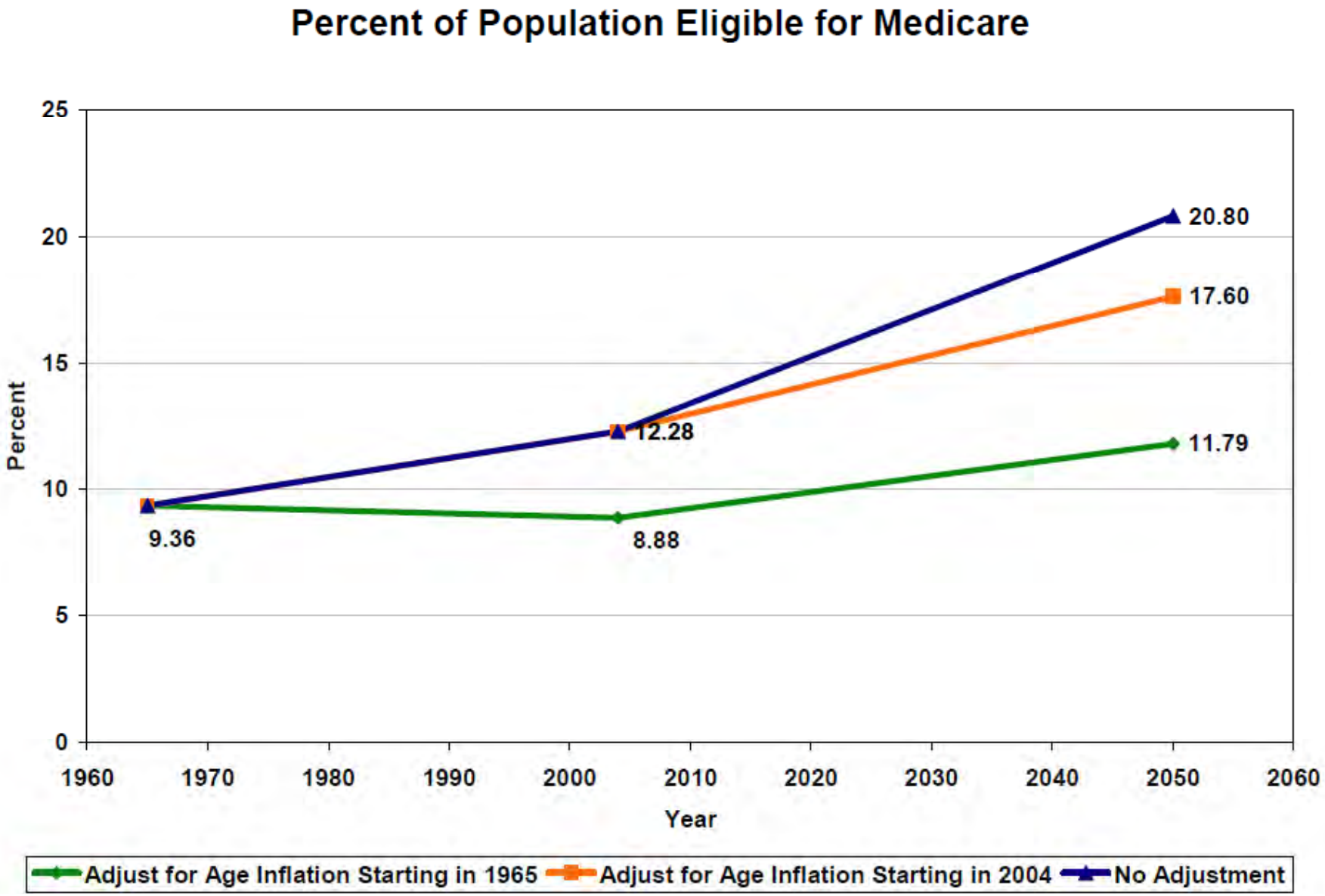

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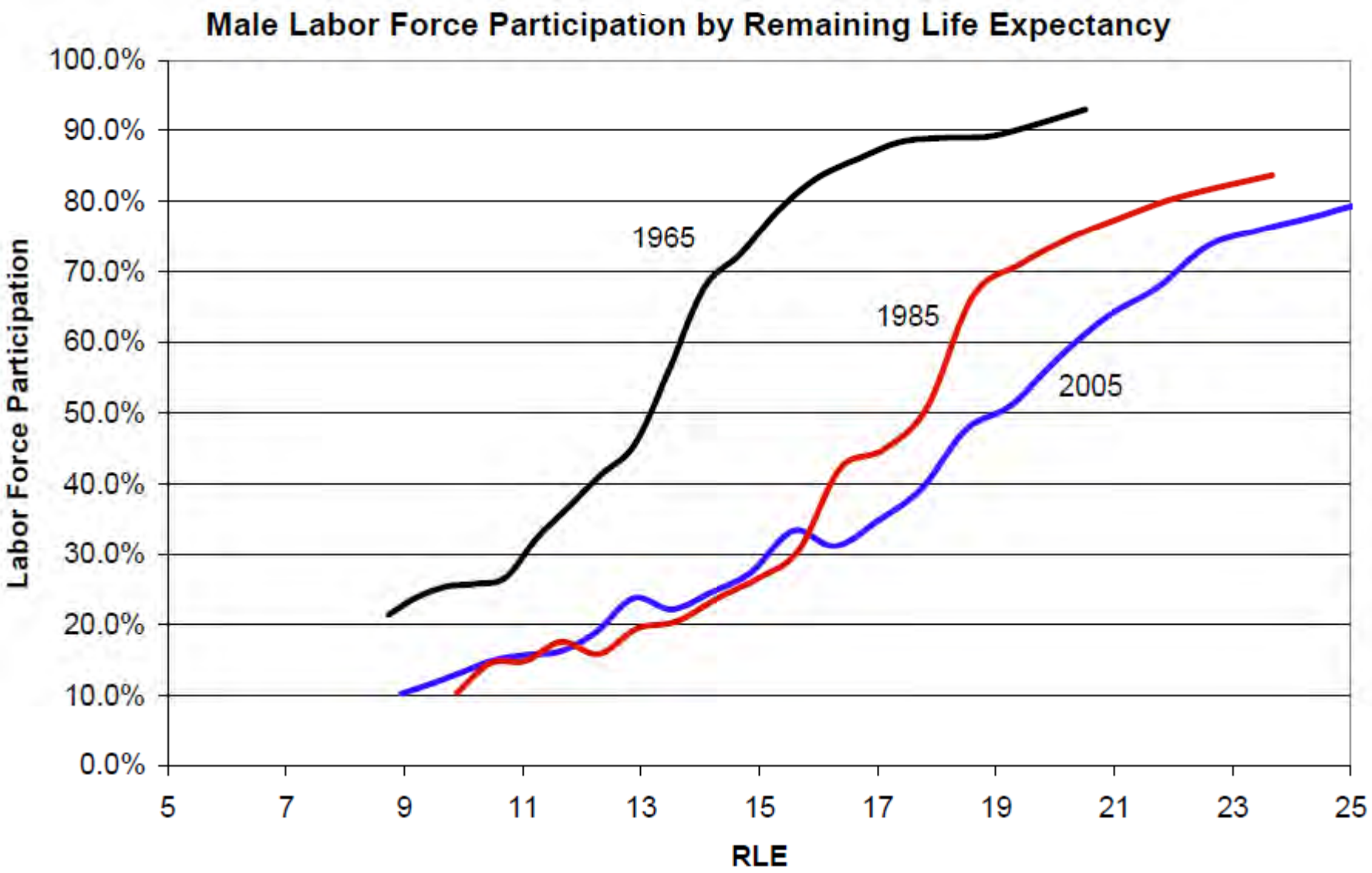

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The ultimate challenge: Can we keep aging Americans healthy longer?


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