Ethics of Healthcare System reform and the ACA

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March 2019

Summary

- How do We Compare?
- Where does our money go?
- Models of other Healthcare Systems
  - Mexico
  - Canada
  - Oregon
- Single Payer Plan and Universal Coverage
- The ACA 2009 and its impact so far.
- Ethics of Healthcare Reform and Fixes still needed for US system.

International Comparisons

	US	Can	France	Japan	NZ
Inf Mor	6.8	5.3	3.6	2.8	5.1
Life Ex	77.8	80.2	80.3	82	79
Smoke	16.9	17.3	23	26	22.5
MRI	26.6	5.5	3.2	40	3.7
$	6401	3326	3374	2358	2343

Achieving a High Performance Health care System. Position Paper, ACP. Ann int med 2008;148:55-75.

Insurance Coverage in USA

- Covered: 250 Mil 84%
- Uninsured 47 mil 15.8
- Uninsured for at least 1 month
  - in last 12 89.5 mil 29.8%
- Underinsured 16 mil 5 %

Uninsured

- Less likely to receive preventive treatment
- Less likely to have access to family physician
- More likely to die prematurely, from preventable illness.
- More complications from illnesses.

Current state of Healthcare USA

- No requirement for insurance.
- Mandates to doctors and hospitals to treat regardless of ability to pay.
- Competition for lowest price, NOT best quality of care.
- A lot of money siphoned out of patient care to HMO profits, Lawyers.

Where does your Healthcare Dollar Go?

- $1.00
  - $0.15 goes to contingency fund to cover lawsuits
  - $0.10 goes to executive compensation and shareholder expenses.
  - $0.05 goes to profit
  - $0.15 goes to Pharmaceutical Companies
  - $0.55 pays for care.

Insurance Company Profits

Company	2008	2009	2010
• Aetna	$1.73 billion	1.27	1.76
• Cigna	800 million	1.3	1.34
• Humana	800 Million	1.04	1.099
• Wellpoint	2.3 Billion	4.75	2.29
• United	3.8 Billion.	3.82	4.63

- Based on reporting to SEC.
- Am Med News May 25, 2009, May 2011
- Margin calculated at 1-5%.

Insurance Company CEO Compensation

- Just the top CEO at the Big 7
  - 2007 $ 87 million
  - 2008 63 million
  - 2009 83 million
  - Plus stock options:
    - United reported $98.6 million to Stephen Hemsley alone in 2009.

Am Med News May 10, 2011

Former United CEO settles in case charging stock backdating

William McGuire, MD, and UnitedHealth Group face other civil and criminal inquiries into how executives maximized their stock options.

EMILY BERRY
AMNEWS STAFF

UnitedHealth Group's former CEO and board chair has settled with the company and the Securities and Exchange Commission over allegations that he benefited from an illegal scheme to maximize what he earned in stock options. But legal troubles remain for both William McGuire, MD, and United.

On Dec. 5, 2007, Dr. McGuire settled with the Securities and Exchange Commission and with pension funds that had brought a lawsuit against him over backdating of stock options, which was alleged to have occurred from 1994 to 2005. The SEC settlement totaled $468 million, the largest ever resulting from options backdating.

Though Dr. McGuire admitted no wrongdoing, the size of the settlement "reflects the magnitude and scope of Dr. McGuire's misconduct," Linda Chatman Thomsen, director of the SEC's enforcement division, said in a prepared statement.

Of that total, $7 million was a civil fine paid to the SEC, another $12.7 million was a return of what the SEC called "ill-gotten gains," and the remainder was a forfeiture of options already issued. The SEC settlement also bars Dr. McGuire from serving as an officer or director in a public company for 10 years.

In the lawsuit settlement, Dr. McGuire agreed to reimburse United for $448 million in options and cash, on top of $200 million in options he gave back upon resigning from United in November 2006, after 15 years with the company. The SEC said the lawsuit settlement, which needs to be reviewed and approved by a U.S. District Court judge in Minnesota, was sufficient to cover the forfeiture it had ordered.

The lawsuit covered other United executives as well. Former general counsel David Ludden agreed to give up $28 million in options, while William Spears, former head of the United board's compensation committee, agreed to submit to binding arbitration to decide his settlement figure. Neither admitted wrongdoing.

Separately, current CEO Stephen Hemsley is in the process of repricing past options, reducing their value by $50 million, on top of $190 million in options he already has surrendered to United. Hemsley, before the settlements, had apologized on behalf of the company for the backdating issues.

Backdating occurs when the strike price of stock options, which is usually predetermined to coincide with a specific date, is adjusted to another date — usually, the one that coincides with the company's lowest stock price of the previous 52 weeks.

Backdating is not illegal if the company informs shareholders in advance that such a plan is in place. But the SEC has investigations under way of at least 14 other companies for doing this, or having boards do it for them, without notifying shareholders. Also, the extra gains from backdating weren't reflected in company earnings, thus causing company profits to be reported as higher than they were, which has caused United and other

UHC Executive Fines 2007

- Mcguire Former CEO
- Hemsley Current CEO
- Ludden Former General Counsel
- Spears Former Comp Comm Chair

- 468 Million Plus…
- 200 million
- 240 million
- 28 million
- Pending
- Total > $1 Billion

14 Other Companies under investigation by SEC.

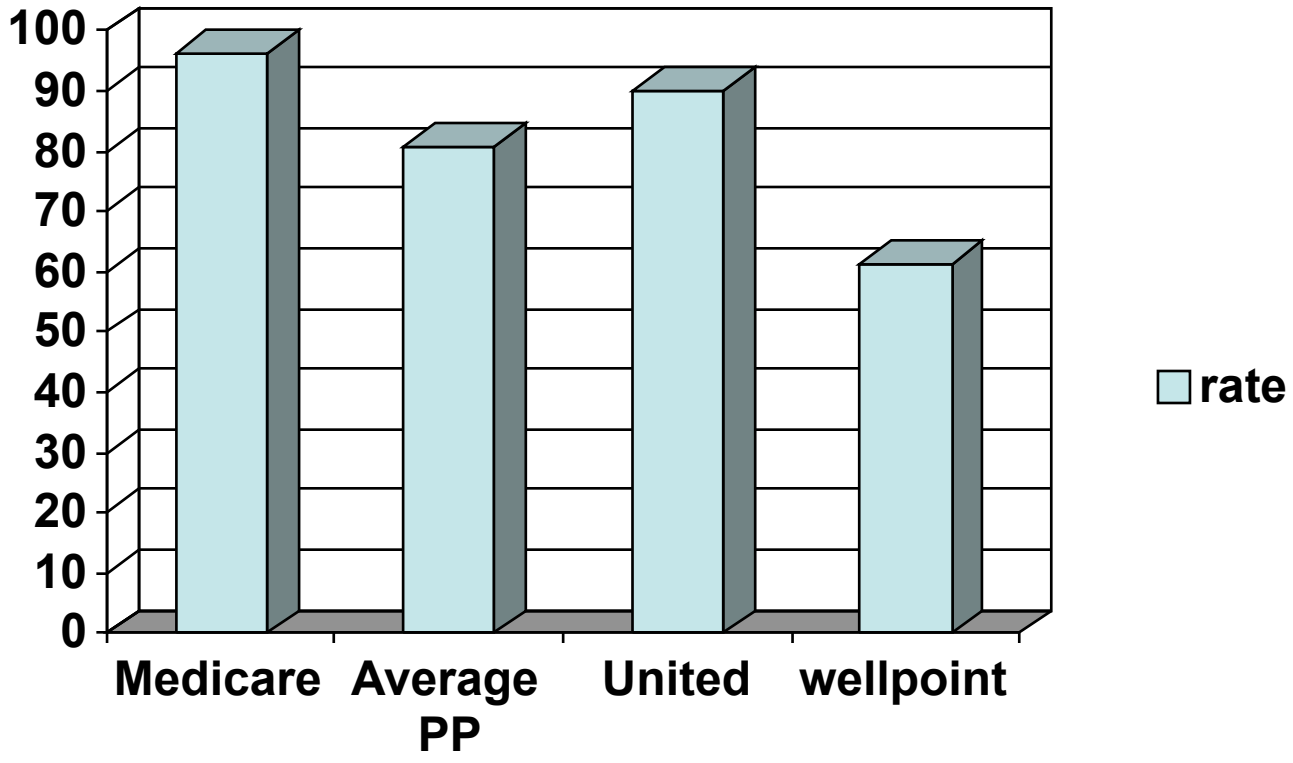
Insurance premiums Rising

Anthem Rate Hikes 2010

Indiana : Average 25 %, Maximum of 39%
Maine: Ave 23%
Oregon Ave 25..3 %
Rhode Island Ave 10.2 % renegotiated to 6.1 % by insurance commission.

Am med News March 8, 2010 Vol 52, number 5, Page 1-4.

Insurers Mishandle 1 in 5 Claims



Initial Claim Accuracy….Am Med News July 11, 2011

USA

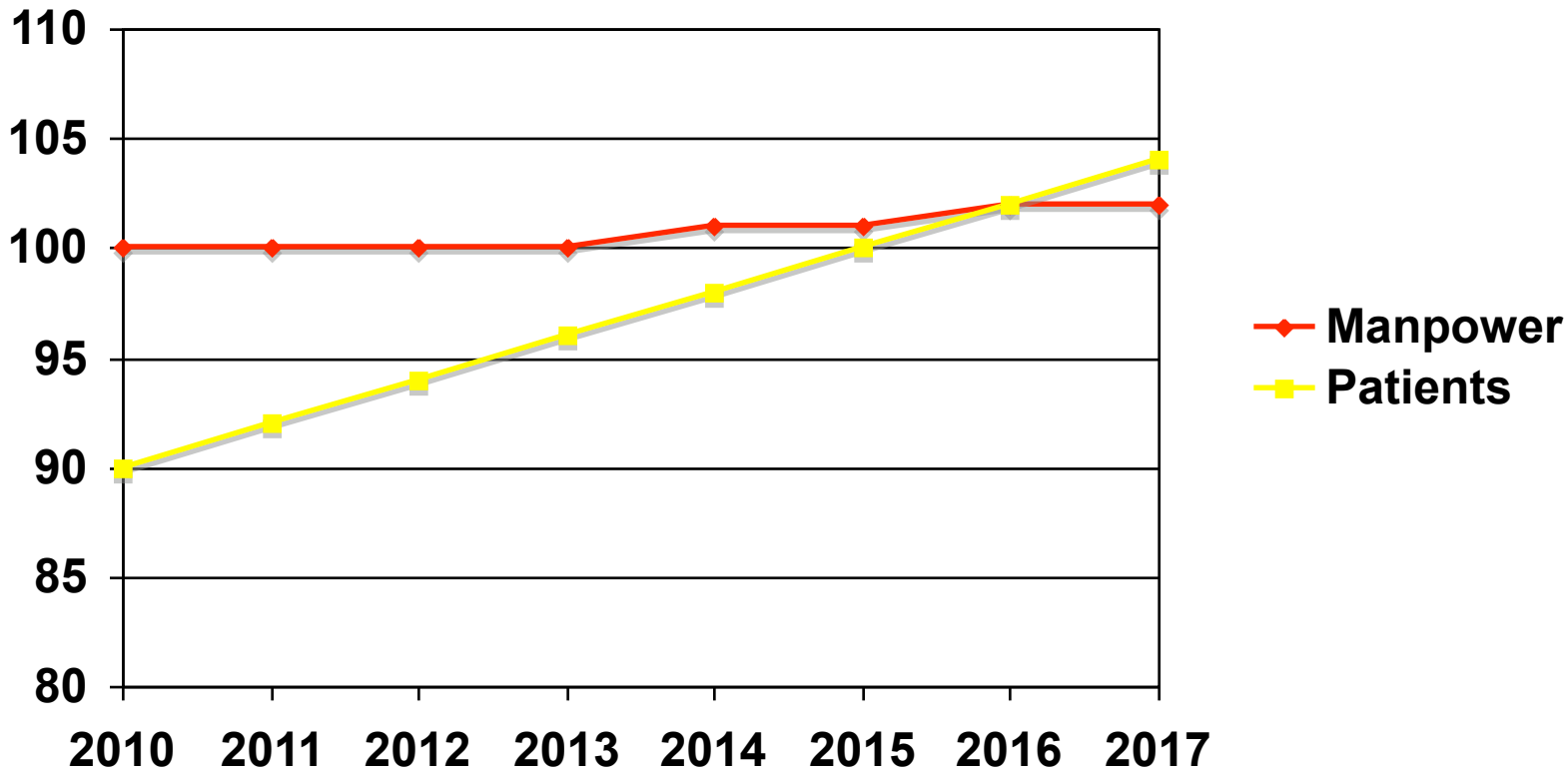
- No emphasis on preventive care.
- 40 million people uninsured.
  - Usually the sickest/ most in need of care.
- Limited support for mental health services due to stigma.
- Competition to cover the healthiest people.
- Hospitals closing not due to demand but due to funding and staffing problems. (US has lowest # of Hospital beds per capita of all industrialized countries).

USA
Other issues

- Cap on training slots for PGE
- Continuous threat to eliminate funds for training.
- Drop in number of applicants for Medical School seats.
- Drop in number of nursing schools.
- Estimated 160,000 physician shortfall.

Result of current trends

Capacity percent



How do Other Systems take Care of Patients?

Models of Healthcare Systems

Mexico

Canada

Oregon

Mexico

- Largely rural population
  - No health care
  - Must travel long distance
  - Medical missionaries help
- Urban population
  - Better jobs mean more access to healthcare, but no guarantee.
  - No job, no money, no care.

Canada

- Single payer plan
- Tax money goes to pay for healthcare for all.
- System is regulated from the top based on budget.
- No cost at time of care or for Rx’s.

Canada Limitations

- Wait list for some procedures
- Physicians and other staff salaried so no incentive to be more productive.
- Decisions made at the top so no chance to appeal if your disease not covered.
- Pts with the means to do so will come to the US to avoid wait, get treatment not covered at home.

Wait Times in the National Health Service, UK, 2019

- Performance is worse in Wales and Northern Ireland than it is in England and Scotland.
- Scotland is the last nation to have hit the target - back in the summer of 2017.
- Meanwhile, in cancer care patients are meant to start treatment within 62 days of an urgent GP referral. But that too is being missed, while waiting lists for routine treatments are rising.
- In England it has topped 4.4 million - the highest on record. Some 15% have waited more than the target time of 18 weeks.

Oregon Medicaid

- Commission to decide how best to spend federal healthcare dollars.
- Assumed preventive services would be fully funded.
- Drew up a list of about 650 diagnoses which could be covered completely.
- Diagnoses and treatments not on the list are not covered.

Oregon Limitations

- Only covers people below poverty level
- No Malpractice reform
- Initially included employer mandate to provide coverage, later abandoned(2004).
- No real effect on private payers, who generally offer LESS than the minimum required by law.
- Up to 2 year wait to get covered.

Answers.google.com “oregon Healthcare system”

What Systems Could we Use?

Single Payer Plan

Universal Coverage

Single payer Plan

- Would be similar to England or Canada.
- Could be simplified, eliminate forms and payment hassles.
- Would allow for transfer of information and follow patient wherever they lived.
- Eliminates problems covering “preexisting conditions”.

Universal Coverage

- Any system which results in all citizens having access to insurance.
- Most require mandates for employers to provide coverage.
- Also include mandates for individuals to have coverage.
- Massachusetts plan (Gov Romney)

Massachusetts plan (Gov Romney)

- Mandates for employers
- Mandates for individuals
- If individual chooses not to pay into plan, that individual must pay out of pocket if they get sick. (does not specify if state will allow pt to die untreated if they refuse to pay and cannot afford care).
- Mandates for Doctors and Hospitals.

Affordable Care Act 2009

- Has saved over 50,000 lives per year!
- Has saved over $12 billion in avoided health care costs
- Resulted in more than 20 million people having Medical Insurance Coverage who could not get it before.
- Forbes Dec 2014

ACA effects

- High risk pools to cover pts with pre-existing conditions like cancer who lost insurance
- Doughnut hole gap closes by 2020
- Insurance plans prohibited from dropping Children with pre-existing conditions like childhood leukemia
- Eliminates the maximal benefit
- Enforces full coverage for preventative screenings for breast, cervical and colon cancer
- Source: cancer.org May 2014

ACA effects

- Mortality is not the only—or even primary—benefit of expanded health insurance, since death is a fairly rare outcome. Quantifying the other benefits—improved quality of life and mental health, improved symptoms, and financial protection—are equally or even more important at a population level, since they're much more common. While our study estimated a "number needed to treat" of 830 people covered to save one life, our secondary outcomes implied that for every 4 people gaining insurance, 1 person had a major increase in overall self-reported health. The Oregon study indicated that for roughly every 11 people covered, there was 1 less person with depression. These are pretty sizable changes that would have to be taken into account in assessing the benefits of expanding coverage.
- New republic.com May 2014

Medicaid Expansion effect on dialysis

- States that expanded Medicaid coverage saw:
  - Reduced mortality among dialysis patients over 1% per year, 8.3% relative risk reduction.
  - Improved fistula rates at start of dialysis
    - States that did not expand saw fistula rates fall
  - 24 % increase in patient seeing a nephrologist prior to starting dialysis.

Nephrology Times Jan 2019

Ethics Role In The Debate on Reform of our Healthcare ***System***

Access to care

Assumptions for Reform

Limits to Care

Ethics and Access to Care

- Every member must have adequate array of core benefits
  - Reform must be comprehensive package to address access, cost, and quality.
- Contents and limits to care must be established through an ethical process.
  - See ethical framework.

Assumptions for Reform

- Transparent - design and administration
- Participatory - creation and oversight
- Equitable and Consistent
- Sensitive to Value/ Cost
- Compassionate - Attention to vulnerable individuals

www.EthicalForce.org

Ethics and Access to Care

- Sustainable
  - Explicit measures of cost/ resources
  - Universality must not be sacrificed to achieve sustainability
- Participants have clear responsibilities for which they are accountable.
  - Monitoring system for misuse.

Better Metrics needed

- Monitor training pipeline
- Monitor how many children of physicians and nurses go into healthcare.
- Survey provider satisfaction, patient satisfaction with care provided.
- ACA provides for a commission to study and monitor the distribution of specialties and offer reforms to increase interest in Primary care

Fixes to America's Healthcare system

- Universal coverage
- Truly Universal coverage implies that the Immigration problem is addressed as well!
- Improve access to prescription meds
  - May require emphasis on generic drugs
  - More education of medical personnel on cost of treatments
  - Government funded advertising of generic drugs "just as good as a Xerox".

Fixes

- Eliminate the malpractice lottery system
  - Best way may be to establish a commission to evaluate law school curriculum, change emphasis of training and improve debt load of law students
  - - Tort reform measures including Noneconomic damage limit of $250,000 would save Federal health Care Programs $ 4 billion ANNUALLY.
  - CBO report October 2009, as quoted in AM Med News March 8, 2010.
- Eliminate debt load of medical students so career decision can be free of constraint.
- Fix Federal budgeting system so there is multiyear funding, to allow for planning and eliminate crisis grandstanding.

Fixes

- 80% of healthcare dollars are spent in last year of life.
- There will need to be a discussion with the public about what is reasonable care and what is unreasonable.
- There is some basis for this.

Britain's NIHCE Commission

- Sets policy on acceptable treatments which will be covered by National Health Insurance. Balances efficacy with cost.
- Based on a calculation of Quality Adjusted Year of Life Saved (QALY).

QALY

- Quality Adjusted Life Year is the measurement of cost of treatment per year of life saved assuming that time is of reasonable quality (not in nursing home or bedridden).
- Can use this to rank treatments for both efficacy and cost.

QALY

- NICE current threshold range is $28 - 42,000 per QALY.
- US surveys suggest a level around 40-100,000 per QALY.
- Recent oncology survey suggests oncologists are comfortable with $280,000 per QALY.

Annals of Int Med Vol 150, no. 8. April 2009. Cancer Care: A Microcosm. Pg 573

Expense of Treatment

- Oncology drug treatment consumes 40% of Medicare Prescription Drug cost
  - Medicare Payment Advisory Commission
    - Report to Congress: Variation and Innovation in Medicare. June 2003.

National Debate on Priorities at End of Life

- This is a loaded issue: see the hysteria raised by the claims of death panels which came from a provision to pay physicians to have a discussion about EOL with their patients.

National Debate on Priorities at End of Life

- Do we want a “Good Death” surrounded by family and friends?
- Death with Dignity?
- Do we want any and all treatments, even if many of them don’t help?
- Do we want to be good stewards of our healthcare resources, so there will be something left to take care of our children?

National Debate on Priorities at End of Life

- The Healthcare Commission could guide a public debate about End of Life care.
- One of the treatments that is offered at the End of Life is CPR and resuscitation.
- While dramatic, it often does not help the patient, and can cause harm.

Survival after resuscitation

- On TV 1980 90 %
  - 2008 75 %
- Surveys of people over 65:
  - Estimate 59% success rate
  - Would want CPR 41 %
  - After explanation of procedure and success rates : 10 % would still want CPR

Intensive Car Med 2007 Feb;33(2):237-45. Epub 2006 Sep 22

Survival after resuscitation

- Incidence of cardiac arrest: 1 per 1200 admissions
- Hospital Survival Rates:
  - Witnessed in CCU 30-40 %
  - Rest of Hospital 15-20 %
  - Sepsis in the ICU 3 %
- OUT of Hospital Arrest 3 %
- With other End Stage Disease: < 1%

Intensive Car Med 2007 Feb;33(2):237-45. Epub 2006 Sep 22

Survival after resuscitation

- Hospital Rates:
  - Incidence of cardiac arrest: 1 per 1200 admissions
  - GVH Deaths reviewed 2005
    - 100 death charts reviewed
    - Approx. 70 of the patients were made DNR before they died. Some were resuscitated one or more times before made DNR.
      - Dr Kaufhold QA review

Intensive Car Med 2007 Feb;33(2):237-45. Epub 2006 Sep 22

Family Understanding of Advance Directives

- 78% of pts with life-threatening illness would prefer to have physician and family make the decision for them.
- 30% of surrogates incorrectly interpret their loved ones written instructions.
  - Am Med News, Jan 12, 2009 pg 8.
  - The Physician Surrogate Relationship. Arch. Int Med. June 11, 2007.

Once Care is limited, Families Accept withdrawal of Care Better.

- Stuttering course of withdrawal is associated with higher family satisfaction.
- The decision takes longer when there are more family members or if a spiritual advisor is involved.
  - Gerstel, Engelberg. Duration of withdrawal of life support in the ICU and association with family satisfaction. AM J Resp Crit Care Med. 2008, 178(8): 798-804.

Proposed Limits to care

- End Stage Diseases will have limits to care, such as DNR orders.
- Patients with these conditions do not survive resuscitation. (1% survival to hospital discharge.)
- Therefore CPR etc is Futile or Nonbeneficial care
- These conditions are chronic and expensive.

Limits to care

- End Stage Diseases
  - Terminal Cancer
    - (I.e. no further curative treatment planned)
  - End Stage Heart disease
    - EF <15%, Defibrillator placement.
  - End Stage Renal Disease
  - Advanced Dementia.
    - PEG tube placement. Low Karnovsky score (<70).
  - End Stage Lung Disease
    - Home oxygen
  - End Stage Liver Disease
    - Bilirubin over 5.0

Limits to Care - Controversy

- Social issues also need to be addressed:
  - Chronic Noncompliance must have consequences to the patient:
  - Result in Hospice referral?
  - discontinuation of treatments such as Dialysis?
  - bar from recurrent hospitalization?
  - There will also need to be protection for physicians
    - Noncompliant pt may not sue doctor for bad outcome.
    - Noncompliant pt data not counted against physician “scorecard” .

Summary

- Comparisons with US healthcare system, Other countries systems.
- Options for improving coverage and reimbursement .
- Trends in care and impact of the ACA
- Ethical considerations in healthcare reform.