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Weekly insights from the Health Research Institute pwc.com/hri

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This week's regulatory and legislative news:

- **Medicare data shines light on physician payments**
- **Physicians say specialty drugs are a big part of Medicare payments**
- **Future of CO-OPs still uncertain, but some positive signs in first year**
- **Proposed Life Safety Code changes could impact accreditation**
- **Hackathons drive the creation of healthcare startups**

Medicare data shines light on physician payments

Although the release last week of data that reveals what Medicare pays individual doctors for some 6,000 procedures is a first step toward a more transparent, consumer-friendly healthcare system, it may also put providers on the defensive. Physician groups for years have blocked the release of such data, raising concerns over the context and scope of the payments. "Most of the amounts shown in the Medicare database for oncologists are not, in fact, revenue to oncology practices," a release from the American Society of Clinical Oncology stated. Similarly, the American Academy of Ophthalmology cautioned that "claims and payment data alone are not adequate proxies for medical necessity of care or outcomes of care." Both types of providers accounted for a high share of Medicare dollars, according to CMS data.

HRI impact analysis: CMS has enthusiastically embraced the move toward more transparency regarding cost and quality data. The massive release of payment data for the more than 880,000 physicians who bill Medicare follows a similar release last year that showed how much the agency reimburses hospitals. The actions are recognition by CMS that the health industry is changing rapidly—becoming more focused on the consumer, who is assuming more out-of-pocket costs for healthcare services. Price transparency is a key part of the new health economy, which will hinge less on fee-for-service payment and more on consumer spending and pay-for-value. At the same time, provider reputations may be at risk because higher than average payments tend to make headlines. If asked about Medicare payments, hospitals and physicians may need to explain what's included when they bill the federal government for their services.

Physicians say specialty drugs are a big part of Medicare payments

After last week's data release some of Medicare's highest-paid physicians are pointing to expensive specialty pharmaceuticals to explain their high reimbursement levels. As mentioned above, the data revealed that Medicare's top billers were specialists, such as ophthalmologists and oncologists that administer high-cost drugs to patients in their offices. Those physicians argue that much of their reimbursement is passed on to drugmakers. One medication used to treat wet age-related macular degeneration—an eye disorder that is the leading cause of vision loss among the elderly—costs approximately $2,000 per dose. Medicare spent over $1 billion on the treatment in 2010.

HRI impact analysis: Greater transparency on physician payments may alter prescribing patterns. Some experts argue that doctors are using expensive therapeutics to increase their reimbursement even though less costly and equally effective treatments are available. Physicians facing increasing scrutiny regarding the payments they receive may rethink which drugs they use to treat patients. That would be welcome relief to purchasers that have mounting concerns about drug costs. HRI's report, Behind the Numbers, cites specialty products as a top contributor to increasing costs in 2014. That trend is likely to continue as new evidence shows rising prices and utilization of specialty products.

Future of CO-OPs still uncertain, but some positive signs in first year

Despite an opening season filled with technical challenges, several of the ACA's 23 new Consumer Oriented and Operated Plans (CO-OPs)—non-profit, member-owned health insurers established with the help of federal loans—appear to be doing well. In Maine, nearly 20,000 people—or about 80% of eligible consumers—chose Maine Community Health Options over the state's only other exchange insurer by early March. As of late February, CO-OPs had enrolled about 300,000 individuals nationwide. Early success may have been primarily due to competitive pricing: several came in as the lowest-priced options in their state. CO-OPs are unable to use government loans to formally market their products.

HRI impact analysis: Early signs look optimistic for several CO-OPs. They represent an alternative, grassroots model of managed care that could prove popular with consumers looking to stay local. However, it's too early to tell whether CO-OPs have long-term viability. It's possible that premium rates will increase in future years as they adjust their actuarial models with real exchange claims data; commercial plans may do the same. CO-OPs will also benefit in the first few years from the 3Rs programs—risk adjustment, reinsurance, and risk corridors—which will help ease the potential negative effects of adverse selection. Long-term success will become clearer once the 3R programs end in 2017, and as CO-OPs are called on to repay government loans. CO-OPs have received about $2 billion in loans from the federal government, with remaining funding for the program cut off as a result of the January 2013 fiscal cliff deal.

Proposed Life Safety Code changes could impact accreditation

Hospitals, long-term care facilities, ambulatory surgery centers, and other health facilities will be required to adopt the 2012 edition of the Life Safety Code (LSC) under a proposed rule released this week by CMS. Published by the National Fire Protection Association, the LSC is not legally binding, but has become the standard for new construction. While facilities built since 2013 are likely compliant with the latest version, many older hospitals have followed the 2000 edition of the code. The new rule includes dozens of proposed changes, such as a ban on certain types of building door locks and an expansion of the types of hand sanitizers that can be used. The proposed rule also loosens a requirement that requires minor renovations to meet the same stringent requirements that new construction requires.

HRI impact analysis: The proposed rule changes would impact a variety of hospital departments, from the operating room to the kitchen—and all points in between. Hospital accreditation groups such as the Joint Commission routinely survey healthcare systems to ensure compliance with either the 2000 edition of the LSC or the 2012 version. Accrediting groups typically follow Medicare's requirements, so hospitals will likely have to make the switch to the newer edition in order to stay compliant. If construction projects are not up to code, hospitals could pay more to bring them into compliance with the most recent edition. Violations of the code could result in the loss of Medicare and Medicaid dollars.

Hackathons drive the creation of healthcare startups

Overnight problem-solving sessions using online health data, known as hackathons, are gaining traction in the healthcare space, in which providers, engineers, entrepreneurs, and developers are coming together to test new ideas and businesses. Hackathon events have recently been held across the country at institutions such as MIT and New York Presbyterian, and internationally in Canada and India. Hackathons are often structured as competitions, in which teams of strangers come together to tackle a particular issue—for example, non-adherence to medication schedules—in a limited amount of time and for a cash prize. "We are not trying to replace the medical culture with Facebook culture," said Elliot Cohen, co-founder of the pharmaceutical startup, PillPack, which was developed to address the medication adherence issue at a recent hackathon. "We want to try to blend them more."

HRI impact analysis: The growing popularity of hackathons in the healthcare arena represents a cultural shift as healthcare, which has typically been slow to innovate, becomes increasingly intertwined with the fast-paced startup world. For the first time, changes in healthcare are coming not only from lengthy clinical trials, but from one-day brainstorming sessions with innovators. As hackathons continue to gain traction, consumers and providers alike should prepare for the emergence of new companies and technologies to address the more detailed issues facing healthcare today.

Upcoming events & deadlines

- **April 30** – Extended deadline for those in the Pre-Existing Condition Insurance Plan to gain coverage through exchanges.
- **May 8 & 9** – FDA's public workshop on implementation of the Drug Quality and Security Act (i.e., track and trace for Rx drugs).
- **May 13-15** – FDA's public workshop on the risk-based regulatory framework and strategy for health information technology.
- **May 31** – 2015 exchange premium rate filing deadline for health insurers.

Quote of the week

"If I had a magic wand and could go back to mid-September and ask different questions based on what I know now, I would," said HHS Secretary Kathleen Sebelius in an interview this week. "I thought I was getting the best information from the best experts, but clearly that didn't go well." The White House announced Secretary Sebelius's resignation late last week, and has nominated Budget Director Sylvia Mathews Burrell to replace her.

In the news

A recent JAMA study by researchers at the University of Pennsylvania found that Medicaid patients were much less likely to receive new patient appointments with primary care doctors than their privately insured counterparts. Only 57.9% of Medicaid callers received an appointment, compared to 84.7% of privately insured callers. The study team made nearly 13,000 calls across ten states during the course of five months.

Factually correct

24 – Number of companies out of the Fortune 50 that are new entrants in healthcare, according to HRI's New Health Economy report. An additional 14 are traditional healthcare companies.

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