U.S. HEALTH CARE: WHAT A WASTE

Many believe that the Bush Administration's greatest mistake was invading Iraq. Others believe that Obama's biggest mistake was authorizing release of $100 billion to Iran when they stop building illegal nuclear weapons. Arguments can be made for both positions, but there is a persuasive contender for worst bipartisan policy mistake they both made: doing little to improve the functioning of the nation's ineffective and bloated health care system. Finally, there is hope that progress will be made in Washington, reshaping the entire health care industry. It takes place at the same time that beneficiaries of ObamaCare - hospitals, managed care companies, and pharma -- must hope that Hillary Clinton wins in November. If she does not, ObamaCare will be repealed, and the companies will give up half of what they have gained in patients and profits.

Consider this. National health care expenditures totaled an eye popping $3.0 trillion in 2014, and accounted for 17.5 percent of GDP. They are expected to be almost 20 percent of GDP in 2024, and are projected to head even higher as the baby boomers age. If Americans enjoyed better health than others living in advanced countries who pay much less for healthcare, it would make sense. But the U.S. spends almost 30 percent more than other developed countries due to waste, not because it buys better health outcomes. Numerous credible studies find that $650 billion to $750 billion are wasted annually. This is an appalling public policy failure. Both the left and the right surely have ideas on what to do with $700 billion a year. For the left it might be universal day care, for the right a major tax cut. Why can't they figure out a way to cut this waste and share in the benefits? Here are three studies that document the health care waste problem and prove that a very large opportunity awaits effective policymakers:

- A 2009 McKinsey study found the U.S. spent $650 billion more than expected when compared to OECD nations.
- A study by Price Waterhouse Coopers identified defensive medicine ($200 billion), inefficient claims processing ($210 billion) and care on preventable diseases ($200 billion) as the top three areas of waste.
- The National Academies of Science Institute of Medicine, in its 2012 book, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, claims that the U.S. wastes approximately $750 billion on Health Care.

Estimated Sources of Excess Costs in Health Care (2009) Institute of Medicine

Category	Sources	Excess Costs ($B)
Total	**All Sources**	**$765**
Unnecessary Services	• Overuse - beyond evidence-established levels	$210
	• Discretionary use beyond benchmarks	
	• Unnecessary choice of higher-cost services	
Inefficiently Delivered Services	• Mistakes - errors, preventable complications	$130
	• Care fragmentation	

	• Unnecessary use of higher-cost providers	
	• Operational inefficiencies at care delivery sites	
Excess Administrative Costs	• Insurance paperwork costs beyond benchmarks	$190
	• Insurers' administrative inefficiencies	
	• Inefficiencies due to care documentation requirements	
Prices that are too high	• Service prices beyond competitive benchmarks	$105
	• Product prices beyond competitive benchmarks	
Missed Prevention opportunities	• Primary prevention	$55
	• Secondary prevention	
	• Tertiary prevention	
Fraud	• All sources—payers, clinicians, patients	$75

We Do Not Get What We Pay For

It gets worse. Preventable deaths from medical errors are the third cause of death in the U.S., after cancer and heart disease, accounting for 400,000 lives lost each year. Someone reading this is likely to die needlessly because of it. This is the equivalent of 2,000 catastrophic commercial airplane crashes annually. Measured in dollars, the cost is estimated at $1 trillion.

To reduce preventable deaths and complications, more practitioners and hospitals will need to practice Evidence Based Medicine. This eventually will happen after the widespread adoption of Health Information Technology (HIT). It will become possible to aggregate the treatment results of 400,000 lung cancer patients, for example, to determine the best-proven methods for treatment, depending on their genetic make-up. Practitioners will be able to access electronic databases with the best treatment protocols as they are helping their patients, and implement them expeditiously. Currently, it can take 15 years for best practices to be implemented on a nationwide basis.

Health Information Technology Yet to Be a Hit

Technology has improved productivity and performance in many industries. But, as Billy Beane, of *Moneyball* fame, Newt Gingrich and John Kerry observed in "How to Take American Health Care from Worst to First," "…a doctor today can get more data on the starting third baseman on his fantasy baseball team than on the effectiveness of life-and-death medical procedures."

The failure of both the Bush and Obama Administrations to require healthcare information software interoperability across the medical community is an important reason why we waste so much money and also have disappointing health outcomes. Maybe, just maybe, this will soon change. Before discussing indications of progress, we present the background.

In their 2005 seminal study on electronic health records, the RAND Corporation found that if medical care productivity increased 1.5 percent per year, mirroring the performance of the retail/wholesale industry after IT adoption, then U.S. health care costs would be $346

billion lower now. Even this jarring number understates Bush/Obama culpability. Health care industry thought leaders surveyed by RAND believed that 8 percent annual productivity gains were achievable by using HIT wisely. Had this happened, health care would cost less than half of what it does today.

As 1.5 billion people on Facebook know, a communications and sharing network works very well when everyone uses the same software platform. But this did not happen in the health care industry. Instead, hospitals and medical offices purchased software from various healthcare information services providers, including McKesson (**MCK**), Cerner (**CERN**), Quality Systems (**QSII**), and Computer Programs and Systems (**CPSI**). Since these companies' software platforms are proprietary, health care providers are unable to exchange health records electronically and seamlessly with those outside their systems. In an error of omission, the Bush Administration failed to create incentives to promote such interoperability when HIT was in its infancy.

In 2009, the Obama Administration made it worse through an error of commission. They stimulated the growth of HIT nationwide by handing out $28 billion in HIT subsidies to hospitals and doctors to encourage adoption. In one sense it worked. The most recent data from 2014 show 51 percent of physicians and 76 percent of hospitals had HIT systems one year ago that meet the Administration's "Stage One" requirements.

In another sense, the HIT build-out created a long-term problem that now must be corrected: many legacy medical infotech systems are proprietary and site-specific by design. HIT providers and developers like it that way. A recent report to Congress shows providers are using "information blocking" to capture profits. Once a hospital or doctor has invested in a particular software system, they become a "locked-in" customer and find it prohibitively expensive to switch software providers. Meanwhile the vendors generate recurring streams of revenue from rigid technologies that hinder interoperability. They are behaving the way cellular phone companies did until cell phone numbers became portable by law.

Hospital and doctors also can be part of the problem. Many think patient data belongs to them and should not be readily portable. If patients were to gain full and portable access to their records, it would be easier to switch hospitals and doctors. This problem has been allowed to grow and fester. Meanwhile, providers worked on meeting the Obama Administration's "Stage Two" requirements. Or so the country thought.

Alas, only 17 percent of hospitals and 12 percent of doctors recently certified that they were Stage Two compliant, despite having more than three years to prepare. This widespread civil disobedience by hospitals and doctors just forced Congress and the Administration to blink and now they are redesigning their program.

The first thing they did was approve provider amnesty. In mid-December the White House and Congress passed S.2425, giving providers a blanket exemption to avoid 2015 noncompliance penalties.

More recently, the Center for Medicare and Medicaid Services' Administrator, Andy Slavitt, claimed it was a new day. He announced this week, "The Meaningful Use program as it has existed, will now be effectively over and replaced with something better."

Slavitt went on to say, "For one, the focus will move away from rewarding providers for the use of technology and towards the outcome they achieve with their patients… We are [also] deadly serious about interoperability. We will begin initiatives in collaboration with physicians and consumers toward pointing technology to fill critical use cases like closing referral loops and engaging a patient in their care. And technology companies that look for ways to practice 'data blocking' in opposition to new regulations will find that it won't be tolerated."

Until HIT systems are "interoperable" many will cost the country money, not save it. And until they are interoperable, America will have one less reason to believe it can bend the health care cost curve. While the Administration redesigns its regulations to do so, the Senate also is developing legislation to attack the Bush/Obama systems incompatibility design flaw.

The Senate Plans to Step In and Improve the Deployment of Useful HIT

Congress has been working on sweeping health IT legislative reform. In early June the House passed the 21st Century Cures Act by a vote of 344-77. In addition to incentivizing pharmaceutical and biotech companies to find more cures, faster, the bill specifies safety and interoperability standards for HIT, and mandates those standards exactly one year later.

The Senate Health, Education, Labor, and Pensions Committee also is hammering out the details of a companion bill to the Cures Act, known as the Innovation Act, that directly deals with interoperability and meaningful use. Chairman Lamar Alexander (R-TN) has "been working with the Obama Administration and Senator Patty Murray (D-WA) diligently for months to develop seven areas of agreement for legislation to achieve HIT interoperability." Watch this space. Politico and other analysts say the bill should pass the Senate before Memorial Day to improve its chances of final passage this year. That will leave time to reconcile House and Senate bills and ship a compromise to Obama before his presidency ends.

Considering the overwhelming support from Congress, Obama can be expected to sign any important bipartisan health bill presented to him. Signing it into law would be a pleasant coda to his presidency because his hoped-for legacy achievement, passage of ObamaCare, may be eviscerated just a few months after he leaves office. We detail why next.

The Future of ObamaCare will be Decided in November

On January 6, 2016, Congress sent H.R.3762, the Restoring Americans' Healthcare Freedom Reconciliation Act to President Obama's desk, which he vetoed two days later**.** This bill "repeals ObamaCare." The significance of this was lost on the press. In reality, it is big news that the GOP Congress has found a parliamentary tactic to power a $1.4 trillion ten-year spending cut and $800 billion ten-year tax reduction bill that guts ObamaCare over the objection of 46 Senate Democrats. Democrats were enfeebled because they could not filibuster it under

Senate rules**.** This process will be repeated in 2017, provided Republicans control both the House and Senate after the November elections.

Unlike the media, the significance was not lost on House Speaker Paul Ryan (R-WI). "Getting past the Senate Democrats has always been the issue, and finally, we cracked the code." Ryan declared at a news conference on January 7, 2016. "We have now demonstrated that, if we elect a Republican president, we can use this same path to repeal ObamaCare without 60 votes in the Senate," Ryan said. "This is critical."

Indeed it is, if you are a health care investor. You now have a major stake in the 2016 presidential election. It is widely, and soundly, believed that if the GOP wins the 2016 presidential election, it also will hold the Senate and the House. Using the tactic known as "reconciliation" again in 2017, the GOP then will drive another repeal bill through Capitol Hill, and send it down Pennsylvania Avenue. But next time, a Republican President would sign it.

That means managed care and pharmaceutical companies, and hospitals are at risk because they are beneficiaries of ObamaCare, and lobbied for it on Capitol Hill. Managed care companies could lose 9 million customers, 5 percent of their total, and even more of their profits. Drug companies could lose 2 percent of domestic sales since the uninsured use half as much in medical care as the insured. But the biggest losers would be hospitals. The major win for hospitals under ObamaCare was the promise that their bad debt expense would shrivel because the number of uninsured patients would fall. The process works in reverse if millions of fewer people have coverage.

The Senate GOP Overcomes the Ghost of Robert Bryd (D-WV) to Repeal ObamaCare

Until it happened, few believed in a mythical "legislative northern passage:" repealing ObamaCare using reconciliation. Using reconciliation was thought to run afoul of the "Byrd Rule," and any attempt to use it faced a certain, and lethal, ruling by the Senate parliamentarian. The late Senator Robert Bryd (D-WV), a former Majority Leader, was a ferocious supporter of the right to filibuster, and he insisted that the scope of the new reconciliation tool, which first appeared in 1981, be narrow. Otherwise, any Senate majority could use it for almost any purpose and strip the minority of its right to filibuster. This would turn the "world's greatest deliberative body" into a smaller version of the House, where simple majority votes decide matters. The two parties reached agreement, limited its scope, and codified it into a federal law. The law is known as the Byrd Rule.

The Byrd Rule forbids using reconciliation to make "policy." Instead it permits its use for "deficit reduction." Technically, therefore, the GOP did not send Obama a bill "repealing ObamaCare." Instead, the GOP dropped the penalty from not getting insurance as an individual, the so-called "individual mandate," from 2.5 percent of household income to zero! Similarly, the employer mandate would still exist, but violators who refuse to comply also would face a "zero dollar penalty," instead of a fine equaling $2,000 per employee. Facing no penalty, people who did not want insurance in the first place, would rejoice and not buy it.

This clever legal maneuver complies with the Byrd Rule. The Congressional Budget Office finds that so many people would stop paying, that the accompanying federal subsidies now given to induce people the reluctant to buy insurance would fall faster than Ben Carson's poll ratings. In addition to cutting spending by $1.4 trillion dollars over ten years, the Act also eliminates $800 billion in taxes used to finance ObamaCare. Besides dropping penalties for not buying insurance to zero, the Act also repeals these taxes:

- the 3.8 percent surtax on net investment income earned by high net worth individuals;
- the increase in the Medicare payroll tax;
- the "Cadillac tax" imposed on family health policies costing more than $27,500.

When assessing the potential impact of repeal under a GOP president, it is important to use realistic assumptions. The GOP cut spending by $1.4 trillion in part by stripping all funding for the Medicaid expansion made possible by ObamaCare, starting in 2018. It is implausible that the GOP actually would follow through and force 5 million or more of the near-poor to lose their insurance coverage. More likely, they would use the time to develop a new approach and there would be no gap in coverage. When assessing the risk to hospitals, insurers, and drug companies, therefore, it is wise to assume that their financial losses would equal half of full repeal.

There is another important caveat. Under the Byrd Rule, some important policies remain in effect and would be defended successfully by Senate Democrat filibuster. For example, the 80 percent minimum medical loss ratio for health insurance companies would remain, as would the prohibition against capping lifetime benefits, despite GOP opposition. The GOP also supports some ObamaCare provisions and would not repeal them. These include the requirement that insurers continue to cover those who get sick or who have pre-existing conditions, and allowing college age children to remain on their parents' policies.

One thing is certain: Washington-generated risks and opportunities to health care investors are not going away. They are about to intensify.

For further analysis or information, contact Capitol Analysts Network, Inc. at:
2230 Decatur Place, N.W. Phone: 202-223-4014
Washington, D.C. 20008
Email: capnet@xecu.net website: www.capitolanalysts.com