

Election 2008

**What does the future hold
for Radiology?**



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Disclosures

- None



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Agenda

- Economic Backdrop
- Healthcare Financial Backdrop
- Medicare
- Value Flow in Radiology
- Threats
- Candidates
- Where do we go from here?



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Economic Backdrop

- Economy in Recession
- Inflationary Monetary and Fiscal Policies are needed
- Worst case scenario has been unfolding
 - Declining consumer spending
 - Greater unemployment
 - Greater uninsured problem (quelled by expansion of Medicaid and SCHIP eligibility)
 - Housing deflationary spiral in the setting of high leverage: yielding sustained slowdown
 - Spillover effects to equity markets



Healthcare Finance Backdrop

- Historical spending (other than a few brief periods) has always been above GDP growth
- We prefer to spend our increasing disposable income on improving our health
 - Income elasticity of demand for healthcare is greater than unity
- Growth in healthcare spending is a fact/given
 - Where that growth is greatest is a big issue/target
 - PhRMA for a while
 - Medical Devices
 - Imaging and Cardiovascular interventions
 - Fastest growth will always draw the attention of the media, the public, and both political parties



Health Care Spending (NHE) 2006

- \$2.1 Trillion up by 6.7 % from prior year. \$7,026 per capita up by 5.7 %
- GDP (nominal) growth 6.1 %
- 16 % of GDP (highest ever, grew by 0.1% this year): Healthcare, as percent of GDP, has been growing since 1997, after a slight decline during the mid 1990s
- Private spending grew at a 5.4% rate and public spending at 8.2% (46.1% of NHE are PUBLIC; up from 43.9% in 1999)
- Public Expenditures (per capita)
 - Overall \$3238
 - Federal \$ 2358
 - State and Local \$888
 - Total U.K. (Public and Private): ~ \$3000 (2003 data was \$2317)



Medicare

- Part A – hitting an absolute wall in the next decade
 - MUST see some reform, but only modest pressure to do anything now
 - Neither the cost nor the reform is palatable
- Part B and D
 - Mandatory appropriation, but legislatively adjustable
 - Big budget and growing
 - Current SGR reductions are **BASELINE**
 - Any fix has an enormous budget impact



Figure II.E1.—Long-Range HI Income and Cost as a Percentage of Taxable Payroll, Intermediate Assumptions

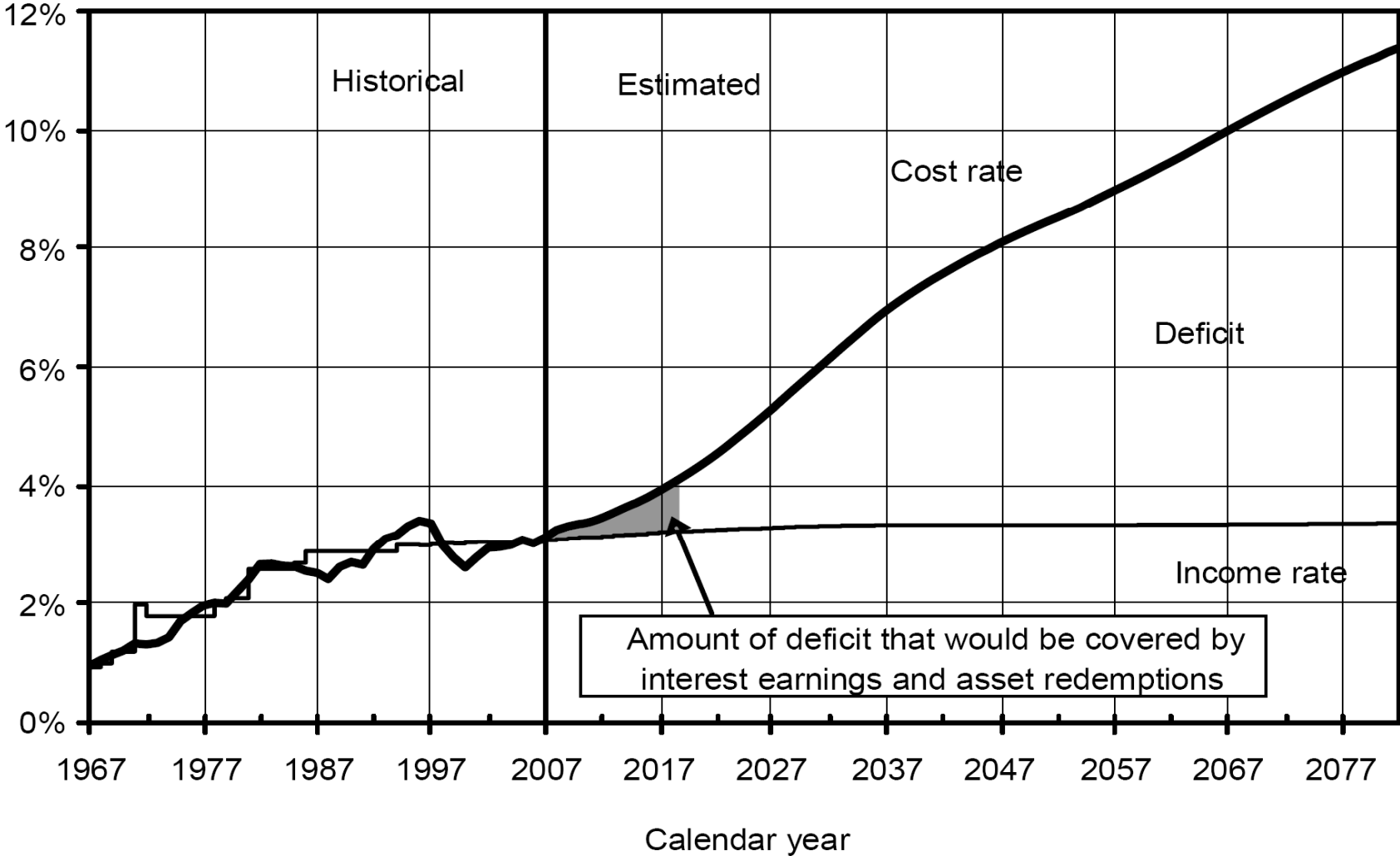
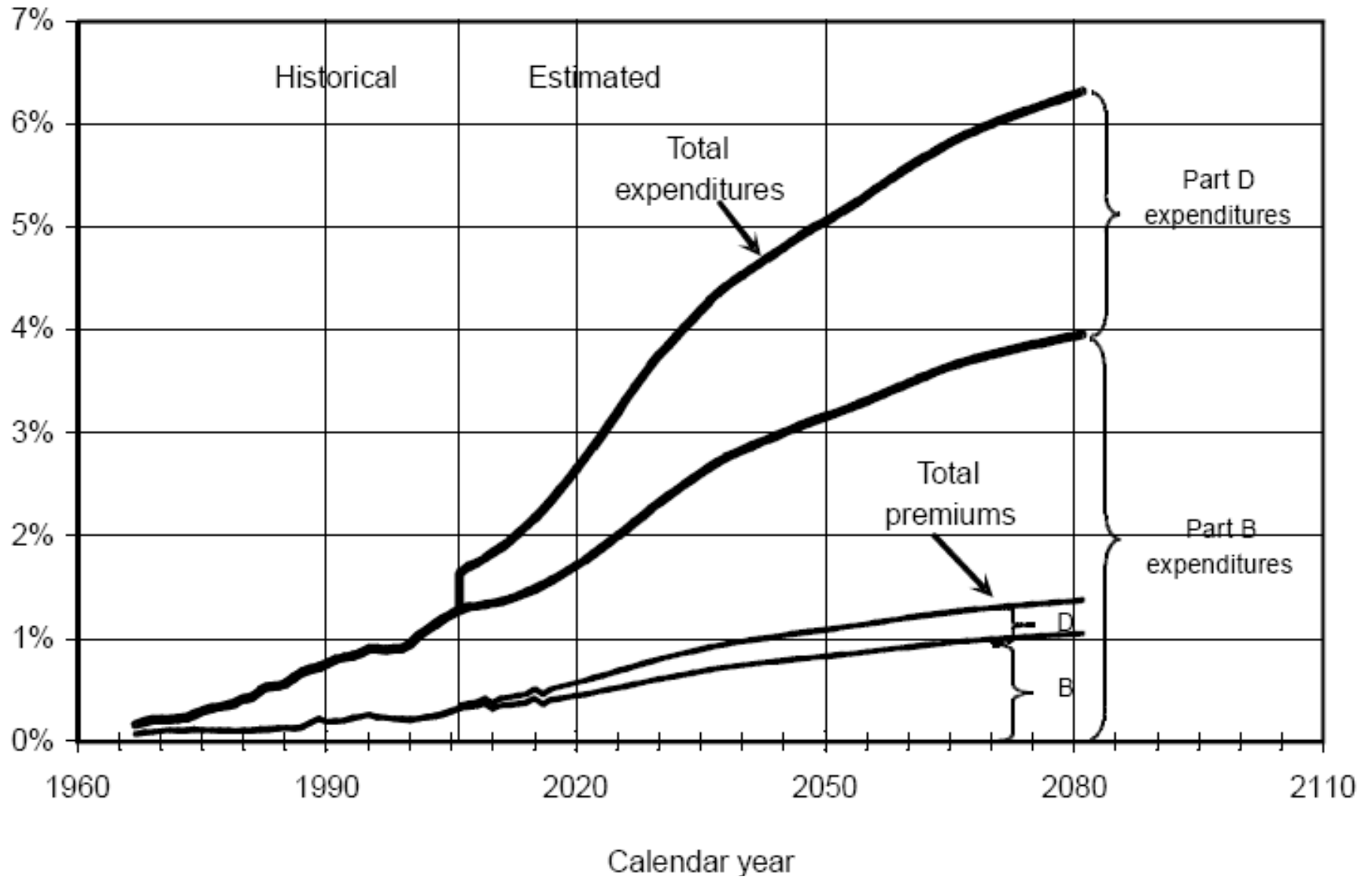


Figure II.F1.—SMI Expenditures and Premiums as a Percentage of the Gross Domestic Product



Medicare: Current Challenges

- DRA – outpatient facility and multi-part examination reimbursement reductions
 - Not evidence based, but easy to enact
- MedPAC
 - Would reverse some DRA changes
 - But would probably offset the effect by reducing technical reimbursement due to archaic assumptions (11% cost of capital and 50% utilization rate for imaging equipment)
- BBA 1997/ Sustainable growth rate legislation
 - Will dramatically reduce all physician fees
 - Could have ripple effects
 - SCHIP renewal



Medicare: Current State

- GAO – June 2008
- Outpatient imaging is growing at unsustainable rates
- Excessive growth in all the usual places
- Increased spending in self-referred imaging

GAO
United States Government Accountability Office
Report to Congressional Requesters

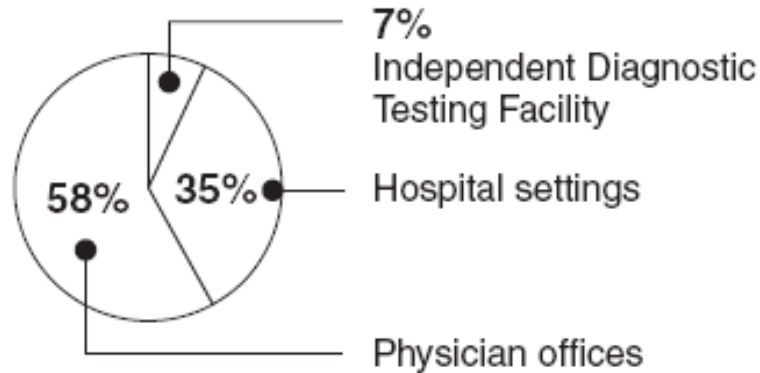
June 2008
MEDICARE PART B
IMAGING SERVICES
Rapid Spending
Growth and Shift to
Physician Offices
Indicate Need for CMS
to Consider Additional
Management Practices

GAO
Accountability • Integrity • Reliability
GAO-08-452



Medicare Part B Spending on Imaging by Setting, 2000 and 2006

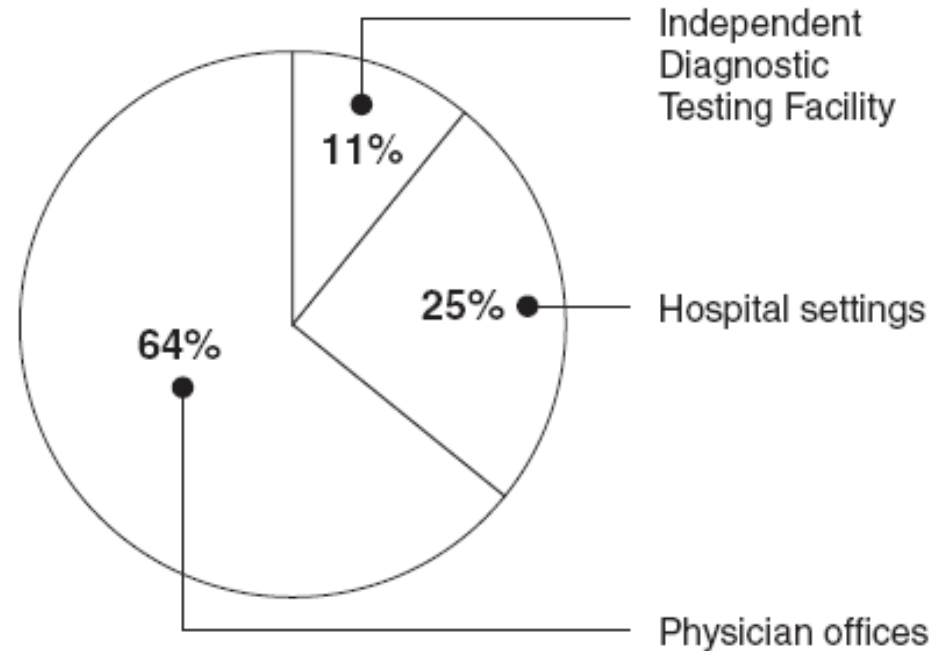
2000 Medicare Part B imaging spending



Total: \$6.89 billion

Source: GAO analysis of Medicare Part B claims data.

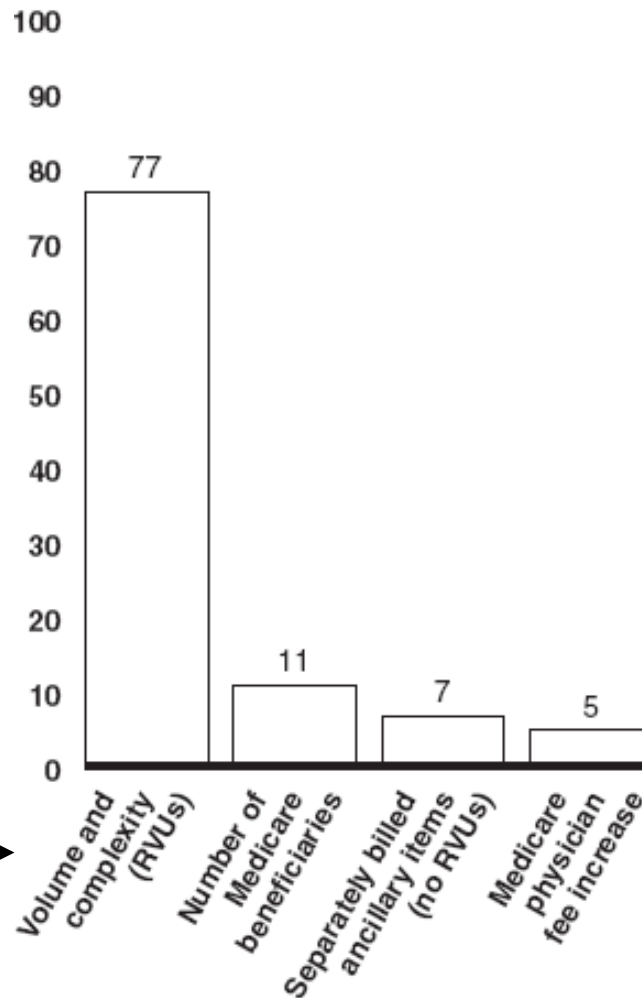
2006 Medicare Part B imaging spending



Total: \$14.11 billion

What influences increase?

Contribution to total spending (percentage)



Biggest factor, almost always!

Factors affecting growth

Source: GAO analysis of Medicare Part B claims data.



Medicare: The future

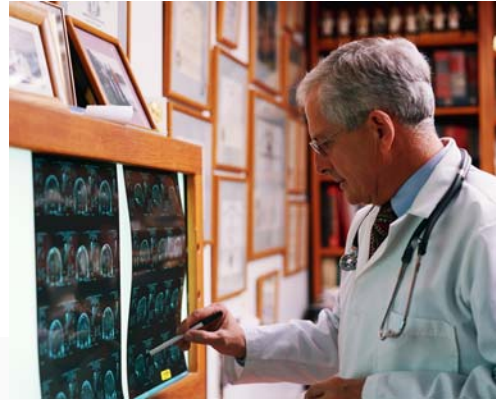
- Reduced spending growth must be achieved for HI (Part A), SMI (Part B) and PDPs(Part D)
- Likely accompanied by tax and cost-sharing increases
- Most effective tools for reduced spending require some combination of empowering consumers, introducing market mechanisms into the program, and removing distorting incentives
- But easiest tools are reimbursement reductions!



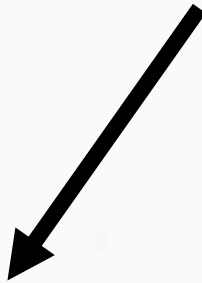
Value Proposition for Imaging

- Fundamentally, insurance reform targets incentives
 - Aligning value with cost
 - Aligning payors (primary and third-party) with cost
- Where is the value in Imaging
 - More accurate diagnoses
 - Detection of disease that is otherwise not observable
 - Guidance of surgical interventions
 - Monitoring of disease and interventions

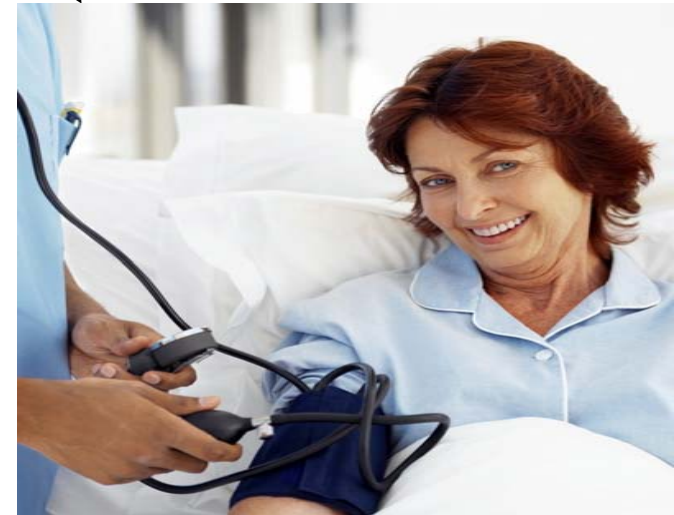




Value?



Value?



Value Proposition

- Where does value flow??
 - SOME to patient
 - Often MORE to primary clinician
 - Appendicitis
 - Line Placements
 - Cardiac Imaging
 - Musculoskeletal Imaging
- Why does this matter?
 - Because it strongly influences the path of any necessary reform



Competitive Threats

- 9 most terrifying words in the English language
- Managed Care – Benefit design
- Threats from outsourcing and competition
- Turf and external threats



Government

- Primarily Medicare
- Ripple effects to all other payers
- SGR – Sustainable Growth Rate Legislation
 - January 1, 2010: makes this a priority for next President and Congress; But kicking the can is more likely
- Physician Quality Reporting Initiative
- Competitive Bidding demonstration project
 - Wheelchairs versus Chest X-Rays
- Spot (and futures?) market for reads?
 - A la David Brailer
- Medicare Advantage
 - Further concentration of buying power in the hands of (larger) entities
- GME Concerns
 - Little reform since 1997
 - Iglehart (NEJM)



Managed Care – Benefit Design

- Pre-authorization/pre-certification
 - GAO report
- Increasing use of RBMs
 - In-house and outsourced
 - AIM purchased by Wellpoint
 - NIA purchased by Magellan
- Co-pays and Co-insurance
 - Previously not used for imaging and laboratory testing
 - Highly effective in Pharmacy Benefit Management
 - # 1 Statin?
- Back to tighter networks with POS plans?
 - Offer every provider, but no co-pays with preferred (i.e., low cost)



Outsourcing Threats

- The opportunity for Nighthawk (as a specific firm, and generically) is **Final Reads**
- Market has not been impressed with the current model
 - Evidence that price competition (commoditization) is occurring
- Future growth must include all payors



Teleradiology/Nighthawk

- Fragmented and interesting industry
- Makes short-term economic sense
 - Typical volume generated by even large practices is insufficient to support the salary/cost of staffing
 - Even if you have to pay more than the revenue generated, it can be prudent with the smallest volumes (even considering that the actual interpretation must follow)
- Issues around fraud/abuse: Is the billing radiologist providing contemporaneous interpretation?
- Internal Nighthawks (Yale) actually provide strategic/comparative advantage: can provide final readings; take advantage of economies of scale; infrastructure/fixed costs already installed



Teleradiology/Nighthawk Survey

- Survey of Non-specialty hospitals (JACR; Kaye et al and Kennedy et al)
- 64 out of 115 practices used an external nighthawk service
- Convenience, value, and shortage of radiologists were reasons given (in that order) for why
- Most practices used these services scarcely: 5% of cases or less
- 2/3 of arrangements resulted in paying more than revenue generated for the arrangement
- Most claim American radiologists or American-trained are doing the majority of the work



Extra-Radiology Threats

- As a specialty, we have always dealt with (and thrived during) turf battles
- Stark Rules and self-dealing concerns
- Gain-sharing (think capture of value)
 - Great opportunity for managed care and Medicare
 - Could be the greatest, ultimate, threat to continued high growth in imaging
 - Emergency Imaging; Oncologic Imaging; Musculoskeletal Imaging



Politics?

- Current congressional priorities do NOT include healthcare reform, despite the rhetoric
- Focus will remain on reactive reform
 - i.e., Medicare
 - SCHIP reauthorization
 - SGR fixes
- Still, it is worth noting the academic and political attention
- Financial Crisis DOES provide some cover for reform
 - Nothing looks very costly when you are already talking \$1T+ deficits!
 - But both candidates will have to show discipline and will abandon all but safety-net support



Key Elements of John McCain's Plan for Health Care Reform.

Elimination of current tax exclusion for employer-paid health insurance premiums

Using revenues generated from eliminating tax exclusion, provision of refundable tax credits (\$2,500 for individuals, \$5,000 for families) for all persons obtaining private health insurance; if insurance costs less than the value of the credit, remaining funds can be deposited into health savings accounts

Creation of guaranteed access plan to provide insurance pool for persons who are medically uninsurable on the individual market

Promotion of individually purchased insurance and less comprehensive insurance policies

Deregulation of insurance markets

Reform of Medicare to make bundled payments for episodes of care and to pay on the basis of outcomes

Other proposed measures to control costs and improve quality:

Enhanced competition

Faster introduction of generic drugs

Emphasis on prevention and better management of chronic conditions

Greater use of health information technology

Medical malpractice reform



Key Elements of Barack Obama's Plan for Health Care Reform.

"Play or pay" employer mandate requiring businesses either to offer workers insurance or to pay a tax (very small businesses would be exempt)

Creation of a new national health plan (similar to Medicare) for the uninsured and small businesses

Establishment of new national health insurance exchange that would offer choice of private insurance options for the uninsured and small businesses

Mandate that all children must have coverage

Subsidies for lower-income Americans to help them afford coverage

Expanded coverage financed through the payroll tax, letting tax cuts for families making over \$250,000 expire, and savings from electronic medical records, disease management, and other system reforms

Regulation of all private insurance plans to end risk rating based on health status

Establishment of federal reinsurance program to insure businesses against the costs of workers' expensive medical episodes

Other proposed measures to control costs and improve quality:

- Reduction in the administrative costs of private insurance

- Accelerated adoption of electronic medical records

- Promotion of disease management

- Emphasis on prevention and public health

- Payment of providers on the basis of performance and outcomes

- Reduction in excessive payments to private plans contracting with Medicare

- Allowing Medicare to negotiate with drug companies

- Establishment of a comparative-effectiveness research institute



Where do we go from here?

- Price Pressures WILL increase
 - Low cost providers will be best-positioned
 - Competition is no longer local
 - If a practice makes too high a demand on local market (managed care or even facility), there are real alternative options
 - Increasing unemployment means increasing uninsured and/or Medicaid/SCHIP
- Count on increasing volume, but plan for slower growth
 - Do not over-hire
 - Put a premium on a flexible workforce
 - Use of RAs, PAs, etc.



Where do we go from here (continued)?

- Deal with local turf issues
 - Based on quality, ability, and competence
 - Do NOT attempt to deal with turf on the basis of title (Radiologist)
 - Hire strategically
 - Cardiac imaging
 - PET Imaging
 - Orthopedic Imaging
 - Staff strategically
 - Do NOT allow outsourcing of any imaging, unless it is absolutely necessary (short term losses may be acceptable)



Strategic Planning

- PQRI – Participate and plan for future
 - Next likely steps
 - Increases in reimbursement will be tied to some metric of quality
 - Reporting times?
 - Reporting information?
 - Outcomes reporting? – not that far off (think MQSA)
- Contemplate open-bidding and what it will mean for your practice
 - Scenario analysis
- Choose (sub) specialty with an eye to the consumer



Good News

- For many reasons, our trainees have been top-caliber for a long time
 - Field is populated with intelligent, ambitious, and technologically adept physicians
 - The pipeline is strong
- Direct relationships between Radiologists and clinical peers make outsourcing, by fiat, unlikely
 - In fact, most outsourcing is from the Radiology Groups, themselves, at this point



Good News

- Since the first dire warnings of our demise (15 years ago), our incomes have (with brief exception) grown faster than most other physician specialties
- We are highly adept at using novel technologies and will continue to do so
- Passivity will not be rewarded; Stay focused on consumers and payers when making decisions
- Future of specialty is not in doubt. Make-up of job will always be changing - be prepared to change with it....



Questions

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