Healthcare Reform and the Cardiovascular Service Line

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Published online October 20, 2017; Updated June 14, 2021

The inaugural article in State of Healthcare comes from Geoffrey A. Rose, M.D., F.A.C.C., F.A.S.E., chief of the Division of Cardiology for Sanger Heart & Vascular Institute in Charlotte, N.C. Dr. Rose serves on the Board of Directors and Advocacy Committee of the American Society of Echocardiography and frequently lectures on the business of healthcare.

Healthcare in the United States is at a crossroads. While amongst the best healthcare systems in developing and implementing novel therapies, it paradoxically ranks amongst the worst in most measures of population health.[1] Compounding this, per capita U.S. healthcare costs are substantially higher than those of any other developed nation. When evaluated from the perspective of system design, the U.S. healthcare system can be characterized as inefficient and underperforming (Figure 1).

To observers of and practitioners within the U.S. healthcare delivery system, this state of affairs has been long recognized. So why are things any different now? What exactly are the implications of recent legislative initiatives, namely the Affordable Care Act and MACRA, on the cardiovascular (CV) care delivery status quo? How should CV service lines organize, or better, *reorganize* care delivery to be successful *status futurus*?

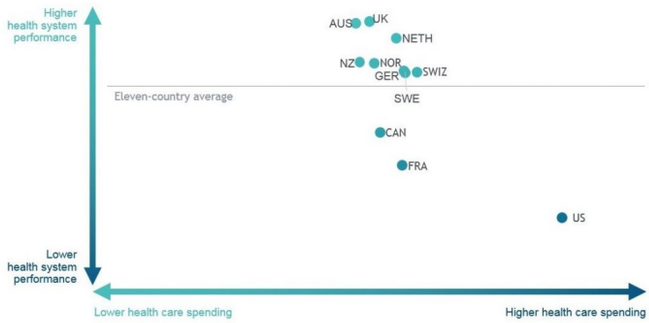

Figure 1.
Health Care System Performance Compared to Spending. Note: Health care spending is expressed as a percent of GDP and spending data is from Organisation for Economic Co-operation and Development (2014) and excludes spending on capital formation of health care providers. Source: E. C. Schneider, D. O. Sarnak, D. Squires, A. Shah, and M. M. Doty, Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care, The Commonwealth Fund, July 2017.

UNDERSTANDING WHAT'S DRIVING HEALTHCARE REFORM

Quality of care notwithstanding, it is axiomatic that any system of healthcare delivery must be undergirded by some financial mechanism. Within the U.S., the funding pool for healthcare comprises the following payers, with their corresponding percentage of market coverage: (1) private health insurance, 33%; (2) Medicare, 20%; (3) Medicaid, 17%; (4) self-insured private business, 20%; and (5) self-funded/out-of-pocket spending, 11%.[2] In total, 46% of healthcare costs are funded by governmental sources (federal 29%; state/local 17%). The annual rate of growth in healthcare spending has decelerated since the passage of the Affordable Care Act (healthcare costs increased by "only" 4.8% in 2016), and it appears that governmental payers have been more effective in restraining the rise in costs as compared to the private market (Figure 2). Nevertheless, the healthcare spending accounted for 17.8% of the U.S. GDP in 2015, and this figure is projected to increase to 19.9% in 2025. No other member nation of the OECD spends > 12% of GDP on healthcare.

To look at U.S. healthcare financing from a different perspective, consider the following:

- Medicare funds healthcare for 57M Americans.
- Over 77M depend on Medicaid or CHIP for funding their care. The fate of these programs rests on to-be-determined policies of a divided U.S. Congress.
- Approximately 28M U.S. citizens remain uninsured.

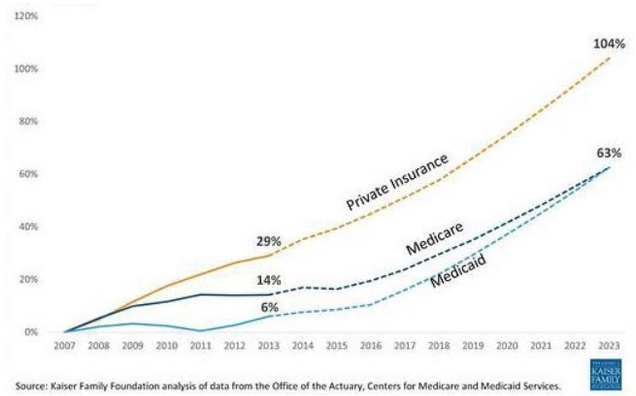

Figure 2.
Cumulative Growth in Per Capita Public and Private Health Spending. Source: Kaiser Family Foundation analysis of data from the Office of the Actuary, Centers for Medicare and Medicaid Services.

Thus, of the estimated 321M in the U.S., > 50% either cannot afford care or instead participate in government-funded payment programs that do not provide sufficient revenue to support the financial expectations of most healthcare systems. This calculus also does not factor in those who are "underinsured," meaning that while they possess private insurance, they cannot meet their deductible or co-payments obligations.

This is present state. What to expect of the future state? Owing solely to the aging of the U.S. population, by 2030 over 80M will qualify for Medicare. This increase in the number of beneficiaries will directly drive an increase in Medicare spending of 2.6% per year through 203.[3] Inflation in spending per Medicare beneficiary will have to be reined to < 2% per year—a level that has never been achieved—if the total increase in Medicare spending is to keep pace with an optimistic 4.4% annual growth in U.S. GDP. Total Medicare spending in 2016 was $588B, and even factoring in today's regulatory policies, it is anticipated to rise to $1.16T in 2027.

Given that Medicare funding accounts for a significant percentage of the total revenue for most cardiovascular (CV) service lines, it is critical to ask: how will this looming increase in Medicare healthcare costs be funded? Presently, there are 3.1 tax-paying workers for every Medicare beneficiary.[3] By 2030, this ratio reaches its nadir—2.3 workers per beneficiary (Figure 3). By virtue of the combination of more beneficiaries and fewer workers to support those beneficiaries, Medicare's Hospital Insurance (Part A) Trust Fund, the portion of Medicare that funds hospital charges and that is funded directly by payroll taxes, will become insolvent in 2029 (Figure 4). What this means is that when Trust Fund is depleted, incoming payroll tax revenues will cover ~87% of projected Part A costs.[4] The implications of this for any hospital service line are profound: absent new funding mechanisms, changes in the qualifying status for receipt of Medicare benefits, or major improvements in the efficiency of care delivery, considerable downward pressure on Medicare reimbursement is expected. These demographic changes and their derivative impact on Medicare reimbursement are of particular relevance to the strategic planning of the CV service line, which will be faced with the twin challenges of (1) meeting increasing demands for care while (2) receiving less reimbursement per episode for doing so. Yet many CV service lines are already struggling to meet today's demand with today's revenues, despite the fact that the today's demands are lower and revenues higher than those expected in the coming decade.

In sum, at baseline the U.S. already spends considerably more than its nation peers on healthcare. Owing to demographic realities, throughout the next decade the overall demand for care (especially CV care) is expected to increase due to aging of the U.S. population. Should the general health of the population deteriorate from its present baseline—in terms of further increases in the incidence of diabetes, obesity, and hypertension—the demand for CV care will increase even more. In attempts to constrain future growth in healthcare costs, the U.S. Congress has passed two major legislative reforms: the Patient Protection and Affordable Care Act of 2010 (aka Obamacare) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The next articles in this series will focus on how the ACA and MACRA are projected to impact CV care delivery and how to restructure care delivery in response. But as outlined above, given foreseeable and inevitable changes in U.S. demographics and their associated macroeconomic impact, today's largely fragmented model of CV care delivery is ill-suited for the future. Our present systems of care cannot simply be "revved" to meet future demands; some major form of CV care redesign is needed. Those CV

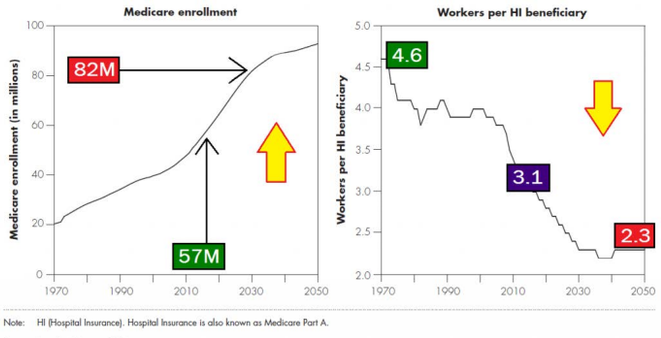

Figure 3.
Medicare enrollment is rising while workers per HI beneficiary is declining. Modified from MedPac Report to the Congress: Medicare and the Health Care Delivery System, 2015.

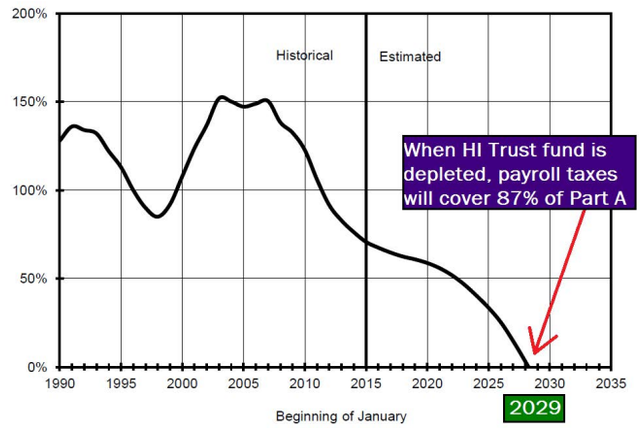

Figure 4.
Hospital Insurance Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures. Modified from 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

service lines that realize that this time it is different and begin to engage in the hard work of care transformation will be the ones best positioned to meet the future needs of the patients they serve.

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