

The Future of Health Care in the United States

**American College of Rheumatology
February 2009**



**AMERICAN COLLEGE
OF RHEUMATOLOGY**
EDUCATION • TREATMENT • RESEARCH

EXECUTIVE SUMMARY

In the fall of 2008, the American College of Rheumatology established a task force on the future of health care in the United States. The task force was established to address health care priorities of the rheumatology community that would increase the value, and improve the delivery of care and the quality of life for people with arthritis, rheumatic and musculoskeletal diseases.*

This document outlines the position of the ACR to achieve these goals.

OVERVIEW

The current health care system is in crisis. It faces the triple threat of uneven quality, unsustainable cost, and increasing numbers of uninsured and underinsured. Over 47 million Americans have no health insurance, and 25 million are underinsured.¹ Continued job loss related to the economic downturn will result in hundreds of thousands more without coverage – further compromising appropriate preventive care and treatment. With tens of millions uninsured or underinsured, skyrocketing health care costs, inadequate incentives for preventive care, and inequities in access to care, there is renewed interest in addressing the flaws of the current system and responding with significant reform. With a new administration and bipartisan support in Congress, the nation is taking on the challenge of health care reform to ensure accessible, efficient and affordable health care for all.

Arthritis, rheumatic and musculoskeletal conditions are the most common chronic diseases, and arthritis is the leading cause of disability in the United States. Eighty-eight million Americans report having a musculoskeletal problem, of which 37 million, or more than 10 percent of the population, report some form of arthritis. Between the years of 2002 and 2004, musculoskeletal conditions were responsible for \$157 billion in medical care expenditures beyond what would be expected for persons of similar ages in the absence of those conditions. Various forms of arthritis were responsible for over \$37 billion in such medical care expenditures. Together, all types of musculoskeletal conditions had an impact equal to almost eight percent of the gross domestic product during this time. The economic impact is likely to grow as the population ages.²

The rheumatology community treats patients with over 100 types of arthritis, rheumatic and musculoskeletal diseases, and other conditions relating to bones and joints. With dramatic improvements in therapies have come increased costs to both the health system and consumer. Patients with these conditions may be at increased risk for other chronic diseases, many of which can either be controlled or prevented. Early access to specialists skilled in the management of rheumatic diseases along with state of the art therapies may decrease the long-term financial burden on the health care system.

** Arthritis, rheumatic and musculoskeletal diseases encompass a broad array of conditions that cause inflammation of or injury to joints, soft tissues such as muscles and tendons, bones, and frequently many other tissues, either directly or indirectly, including blood vessels, the heart, lungs, the nervous system, and kidneys. Common disorders are rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, lupus, scleroderma, osteoarthritis, gout, osteoporosis, fibromyalgia, and regional pain syndromes such as back pain, shoulder and knee afflictions, and bursitis.*

THE POSITION OF THE AMERICAN COLLEGE OF RHEUMATOLOGY

The ACR places patient care at the forefront in treating arthritis, rheumatic and musculoskeletal diseases. Providing timely access to high quality care can reduce disability and improve quality of life. However, many patients with these conditions do not have access to high quality care because they lack insurance or have insufficient coverage.

To ensure access to care, the ACR supports:

- 1) Access to affordable health coverage
- 2) Access to an adequate health care workforce for arthritis, rheumatic and musculoskeletal diseases
- 3) Access to quality care for these diseases
- 4) Cost-effective care without reduction in quality health care

Ensure Access to Affordable Health Coverage

To ensure access to affordable health coverage, the ACR supports:

- Universal access to affordable insurance coverage through a choice of competing private or public comprehensive health insurance plans
- The establishment of a national, standardized minimum benefit package across public and private health plans, similar to the Federal Employee Health Benefit Plan

To ensure these goals:

- Pre-existing condition clauses must be eliminated from all health plans.
- Health plans must be portable.
- Participation by all legal residents in a private or public health plan

Ensure Access to an Adequate Health Care Workforce for Arthritis, Rheumatic and Musculoskeletal Diseases

Evidence indicates that rheumatologists achieve better outcomes in treating patients with arthritis, rheumatic and musculoskeletal diseases – compared to primary care providers and other specialists. However, there are too few rheumatologists to provide adequate care for all children and adults with these conditions. Furthermore, the impending shortage of primary care providers may further delay early screening and appropriate referral. Both are necessary to provide high quality care.

To ensure access to an adequate health care workforce to treat patients with arthritis, rheumatic and musculoskeletal diseases, the ACR supports:

- Increased funding for the training of rheumatologists and other rheumatology health care providers
- A loan forgiveness program for the training of pediatric rheumatologists as their numbers are at a critical low
- Increased reimbursement for non-procedural (cognitive) care, which includes chronic disease management and coordination of care with the goal of preventing long-term disability
- An adequate number of primary care providers

Ensure Access to Quality Care for Arthritis, Rheumatic and Musculoskeletal Diseases

There are an increasing number of treatments for the arthritis, rheumatic and musculoskeletal diseases of proven efficacy for which there is strong evidence of cost-effectiveness. However, current health policies impede access to these treatments because of the increasing out-of-pocket burden on patients. Burdensome requirements are also placed on health care providers.

To ensure access to quality care, the ACR supports:

- Federally mandated limits to out-of-pocket payments for cost-effective and appropriate care of these diseases, such as:
 - The development of a more comprehensive, centralized appeals process, with criteria that are based on scientific evidence, for addressing denial of claims
 - The removal, or significant reduction, of the Medicare Part D “doughnut hole”
 - The elimination of the Tier IV copayments for medications
- Preventing payors from imposing quality measures that lack scientific evidence or are based solely on cost savings.
- Permitting negotiations to ensure that drugs are available and affordable.

To ensure high quality rheumatologic care, the ACR supports:

- The expansion of research into prevention of these diseases and effectiveness of treatments of the existing conditions through increased funding for health services research at the Agency for Healthcare Research and Quality, National Institutes of Health, and other public and private institutions
- The development of guidelines for quality measures by health care providers in their respective specialties
- Government assistance in introducing health information technology practices to ensure interoperability of systems and protection of patient privacy and that the adoption of such technology is affordable
- Full disclosure of physician and payor relationships with pharmaceutical companies to avoid both perceived and real conflicts of interest

To promote patient participation in the quality of their care, the ACR supports:

- The investment in education, awareness, and prevention programs that promote healthy lifestyles and potentially prevent some chronic diseases

Ensure Cost-Effectiveness without Reduction in Quality Health Care

To reduce skyrocketing health care costs and inefficiencies in health care delivery, and to ensure that a greater percentage of every health care dollar is directed toward clinical care, the ACR supports:

- The reduction of the administrative burden on clinical practices by nationally standardized billing procedures, pre-authorizations, credentialing, etc.
- The reduction of the costs associated with the practice of defensive medicine and rising medical malpractice insurance premiums through comprehensive tort reform
- The study of innovative models of health care delivery and practice efficiency that have been shown to achieve good health outcomes at reasonable cost

FINDINGS OF THE AMERICAN COLLEGE OF RHEUMATOLOGY

Ensure Access to Affordable Insurance Coverage

Universal access to affordable health insurance coverage is essential to the delivery of effective care and is necessary to ensure a healthy, productive workforce.

The percentage of people (workers and dependents) with employment-based health insurance has dropped from 70 percent in 1987 to 59 percent in 2006. This is the lowest level of employment-based insurance coverage in more than a decade. In 2006, 37.7 million of those workers were uninsured because not all businesses offer health benefits, not all workers qualify for coverage and many employees cannot afford insurance even when coverage is offered.

Those living in the United States who do not have insurance, or are underinsured, compromise their health by delaying preventative care. As a result, they are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have increased morbidity and mortality rates than those with health insurance.³ These factors result in increased health care costs and reduced productivity. Providing universal access to insurance is necessary to ensure access to affordable health care.

Recommendations

To ensure access to affordable health insurance coverage, the ACR supports:

- Universal access to affordable insurance coverage through a choice of competing private or public comprehensive health insurance plans
- The establishment of a nationally standardized minimum benefit package across public and private health plans, similar to the Federal Employee Health Benefit Plan

To ensure these goals:

- Pre-existing condition clauses must be eliminated from all health plans
- Health plans must be portable
- Participation by all legal residents in a private or public health plan

Ensure Access to an Adequate Health Care Workforce for Arthritis, Rheumatic and Musculoskeletal Diseases

Evidence indicates that rheumatologists achieve better outcomes in the treatment of arthritis, rheumatic and musculoskeletal conditions compared to primary care providers and other specialists.⁴ Primary care providers often lack adequate rheumatologic training. They are less skilled in the diagnosis and management of these diseases and may order more diagnostic studies, drugs, consultations and follow-up visits than rheumatologists, making the care they provide lower quality and more costly. Rheumatologic care for these conditions provides better patient outcomes and is less costly to the health care system.

However, there is a shortage of rheumatologists to care for children and adults with arthritis, rheumatic and musculoskeletal diseases. Based on assessment of supply and demand under current scenarios, the demand for both adult and pediatric rheumatologists is expected to exceed supply in the coming decades. By 2025, it is anticipated that the demand for rheumatology care will exceed supply by 2,576 adult and 33

pediatric rheumatologists.⁵ An inadequate rheumatology workforce decreases access-to-care for the 88 million Americans living with arthritis, rheumatic and musculoskeletal diseases.

Rheumatology is a cognitive (non-procedural) specialty integrally involved in chronic disease management. Rheumatologists must spend considerable time analyzing symptoms and patient information to determine the correct diagnosis and best treatments. Payors (i.e., Medicare, Medicaid and private insurers) reimburse cognitive provider specialties inadequately compared to higher technology, procedure-based specialists.⁶ Insufficient compensation for cognitive care is a major barrier in the recruitment and retention of an adequate workforce to meet the increased demand for rheumatology services.⁷

Increased reimbursement for rheumatologists and other cognitive specialties allows for more time with patients ensuring the most effective treatment and highest quality of care and potentially reducing overall health care costs. Adequate reimbursement also could decrease the projected rheumatology workforce shortage by removing the financial barrier of choosing a career in rheumatology.

There is a severe shortage of pediatric rheumatologists. In 2005, there were only 218 pediatric rheumatologists in the United States.⁵ As a result, the 294,000 patients with juvenile arthritis (the chronic inflammation of one or more joints that develops in a person younger than 16) have limited access to high-quality care for their conditions. The shortage of pediatric rheumatologists and other pediatric subspecialists must be addressed to ensure access to high-quality care for children.

Rheumatologists often do not provide continuous primary care for their patients. Thus, patients should have coordinated and comprehensive primary care from a single provider in addition to rheumatology care to ensure high-quality care. However, there is also a shortage of primary care providers and the expansion of health care coverage will significantly increase the need for primary care physicians.

Regions that have an adequate primary care work force have coordinated care, better health outcomes, and lower costs for patients. Without an adequate primary care work force, care becomes fragmented and more costly and could lead to poorer outcomes of chronic diseases. An adequate primary care workforce facilitates timely and appropriate referrals to specialists, which is essential in the chronic disease management of arthritis, rheumatic and musculoskeletal diseases.

Recommendations

To ensure access to an adequate health care workforce to treat patients with arthritis, rheumatic and musculoskeletal diseases, the ACR supports:

- Increased funding for training of rheumatologists and other rheumatology health care providers
- A loan forgiveness program for the training of pediatric rheumatologists as their numbers are at a critical low
- Increased reimbursement for non-procedural (cognitive) care, which includes chronic disease management and coordination of care with the goal of preventing long-term disability
- An adequate number of primary care providers

Ensure Access to Quality Care for Arthritis, Rheumatic and Musculoskeletal Diseases

There are an increasing number of treatments for arthritis and other rheumatic and musculoskeletal diseases of proven efficacy and cost-effectiveness. Utilization of these medications can prevent disability

and job loss and increase individual productivity and tax revenues from continued ability to work. However, increased cost sharing leading to a greater out-of-pocket burden on patients is forcing many to forgo these highly effective treatment options.³ In addition, a variety of administrative barriers are placed by payor and formulary committees to restrict utilization, effectively making therapeutic decisions in place of the patient's physician. Burdensome requirements are also placed on health care providers.

Recommendations

To ensure access to quality care, the ACR supports:

- Federally mandated limits to out-of-pocket payments for cost-effective and appropriate care of these diseases, such as:
 - The development of a more comprehensive, centralized appeals process, with criteria that are based on scientific evidence, for addressing denial of claims
 - The removal or significant reduction of the Medicare Part D “doughnut hole”
 - The elimination of the Tier IV copayments for medications
- Payors should not impose quality measures that lack scientific evidence or are based solely on cost savings.
- Negotiations should be permitted to ensure that drugs are available and affordable.

Research funded by the Agency on Healthcare Quality and Research and the National Institutes of Health has made significant advances in the knowledge and treatment of arthritis, rheumatic and musculoskeletal diseases.⁸ Continued research will lead to new drug therapies for the treatment of these diseases.⁹ Further research is needed to explore scientifically proven quality measures that can be used by physicians to judge their own success at providing care that is state of the art and of the highest quality.

Health information technology and, specifically, interoperable electronic health records are a valuable tool to improve health care delivery and quality of care. The development of a standard EHR system should allow quick retrieval of patient records, result in fewer medical errors, prevent costly duplication of laboratory and radiographic tests, ease development of—and adherence to—clinical guidelines, facilitate quality outcomes for patients and—if linked to chronic disease data registries—will produce a new era of evidence-based medical care.

However, despite its potential to improve quality, reduce medical errors and lower overall health care costs, EHR implementation is costly especially to small office practices, which represent a large proportion of practicing rheumatologists in the U.S.

Providers and patients also depend on industry to do extensive research, share knowledge, and improve patient care. However, paid relationships between physicians and health care industry represent potential conflicts of interests and threaten the trust between physicians and their patients. Therefore, transparency is necessary to discourage inappropriate arrangements between providers and industry and to ensure that providers' decisions about care are independent of industry influence and are based on good medical science. Transparency of price and quality is also necessary to ensure that patients have a clear choice in selecting their health care to ensure the greatest value.

Recommendations

To ensure high quality rheumatologic care, the ACR supports:

- The expansion of research into prevention of these diseases and effectiveness of treatments of the existing conditions through increased funding for health services research at the Agency for Healthcare Research and Quality, National Institutes of Health, and other public and private institutions
- The development of guidelines for quality measures by health care providers in their respective specialties
- Government assistance in introducing health information technology practices to ensure interoperability of systems and protection of patient privacy and that the adoption of such technology is affordable
- Full disclosure of physician and payor relationships with pharmaceutical companies to avoid both perceived and real conflicts of interest

Chronic disease management with a focus on control and, where possible, prevention must be a priority for the future of health care. Patients should be educated and encouraged to take personal responsibility in their health care. Educational programs on healthy living including smoking cessation, weight control, nutrition, and exercise will help in the prevention of avoidable illnesses. Patients with arthritis, rheumatic and musculoskeletal diseases have increased risk of comorbidities, and educational services and awareness programs could assist them with their chronic diseases.

To promote patient participation in the quality of their care, the ACR supports:

- The investment in education, awareness, and prevention programs that promote healthy lifestyles and potentially prevent some chronic diseases

Access to Cost Effectiveness Without Reduction of Quality Health Care

High administrative costs contribute to skyrocketing health care costs.¹⁰ Innovative models of health care delivery could provide coordination and streamline patient care without reducing quality and could contain rising health care costs.

Practice of defensive medicine to avoid liability also contributes to this cost. Tort reform at the state and federal level could decrease the administrative cost¹¹ and burden of frivolous lawsuits¹² and allow credible claims to be compensated fairly and quickly.

Recommendations

To reduce skyrocketing health care costs and inefficiencies in health care delivery, and to ensure that a greater percentage of every health care dollar is directed toward clinical care, the ACR supports:

- The reduction of the administrative burden on clinical practices by nationally standardized billing procedures, pre-authorizations, credentialing, etc.
- The reduction of the costs associated with the practice of defensive medicine and rising medical malpractice insurance premiums through comprehensive tort reform
- The study of innovative models of health care delivery and practice efficiency that have been shown to achieve good health outcomes at reasonable cost

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