The New Vision for the Optical World
“ A Paradigm Shift of Major Proportions”

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Chief Medical Officer
How did we get here in the first place?
And even more importantly, why?
The History of the US Healthcare System

1920-1930  Period of rising medical costs spawned by regulation of the practice of medicine and hospitals

1930–1940  Emergence of first insurances
  • Blue Cross – Hospitals
  • Blue Shield – Doctors

1940–1960  Supply and demand for health insurance resulted in growth of the insurance market
Number of Persons with Health Insurance (thousands) 1940-1960
The History of the US Healthcare System

1960s  First Entitlement Program

Medicare
- Age 65+ (1965)
- Number of eligible patients – 19 million
- Average Life Span – 66 years

Medicaid
- Poor individuals with dependent children
- Number of eligible patients – 10 million

1972  Medicare adds coverage to those individuals under 65 but disabled or with End Stage Renal Disease

Payment
- Part A (Hospitals) Full and reasonable cost
- Part B (Physicians) Used Customary and Reasonable and overbill patients
The History of The US Health Care System, cont’d.

1983 Medicare Introduces Prospective Payment System
• Response to increasing costs
• Specific pay for specific diagnosis

1988 HMO and Capitation
• Fixed fee to manage care of defined patient population
• No specific quality metrics
• Less $ spent More $ providers/payers
• Probably the Most Ill Thought Out Program in History
1990 – Today

• Health Care costs continue to escalate at astronomical rates

• Modern medicine has become very successful at keeping our patients alive for a long time

• New Technologies abound and most at very high price points

• Patient demand high as chronic conditions evolve: Obesity, Diabetes, and Hypertension
US Healthcare Spending

2018: $4.4 Trillion

2012: $2.8 Trillion
How did healthcare spending vary by nation in 2012?

(The Business Insider.com, 2013)
Total Health Expenditure per Capita, U.S. and Selected Countries, 2011

U.S. PUBLIC Spending Per Capita for Health is Greater than TOTAL Spending in Other Nations

International Comparison of Spending on Health, 1980-2010

Average spending on health per capita ($US PPP)

Total health expenditures as percent of GDP

Notes: PPP = purchasing power parity; GDP = gross domestic product. Source: Commonwealth Fund, based on OECD Health Data 2012.
Health Care Cost Problem - US

National Health Expenditures Per Capita, 1990-2019

Historical

$2,814 (1990)

Projected Per Capita

$8,047 (2009)

$13,387 (2019)

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at
Overall Administrative Costs
United States & Canada, 2010

Source: Woolhandler/Himmelstein/Campbell NEJM 2003; 349:768 (updated)

Source: Bureau of Labor Statistics; NCHS; and Himmelstein/Woolhandler analysis of CPS
Given that we spend more on health care than any other country in the world, the most important question then becomes...

**Are we getting what we paid for?**
US ranked 37th by the WHO World Health Report

**Life Expectancy**

<table>
<thead>
<tr>
<th>Years</th>
<th>U.S.</th>
<th>Germany</th>
<th>U.K.</th>
<th>Canada</th>
<th>France</th>
<th>Sweden</th>
<th>Italy</th>
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<tbody>
<tr>
<td>70</td>
<td>78.2</td>
<td>80.3</td>
<td>80.4</td>
<td>80.7</td>
<td>81</td>
<td>81.4</td>
<td>81.8</td>
</tr>
</tbody>
</table>

Source: OECD, 2011
Note: Data are for 2009 or most recent year available

**Infant Mortality**
Deaths in First Year of Life/1000 Live Births

<table>
<thead>
<tr>
<th>Deaths</th>
<th>U.S.</th>
<th>Canada</th>
<th>Australia</th>
<th>France</th>
<th>Italy</th>
<th>Germany</th>
<th>Sweden</th>
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<tbody>
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<td>6.5</td>
<td>5.1</td>
<td>4.3</td>
<td>3.9</td>
<td>3.7</td>
<td>8.5</td>
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Source: OECD, 2011
Note: Data are for 2009 or most recent year available

**Maternal Mortality**
Deaths/100,000 Births

<table>
<thead>
<tr>
<th>Deaths</th>
<th>U.S.</th>
<th>U.K.</th>
<th>Canada</th>
<th>France</th>
<th>Germany</th>
<th>Australia</th>
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</thead>
<tbody>
<tr>
<td>12.7</td>
<td>8</td>
<td>7.8</td>
<td>7.6</td>
<td>5.3</td>
<td>2</td>
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</table>

Source: OECD, 2011
Note: Data are for 2009 or most recent year available
Hemorrhagic Stoke Mortality
In-Hospital 30 Day Case-Fatality Rate

Deaths per 100 patients

<table>
<thead>
<tr>
<th>Country</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Sweden</td>
<td>12.8</td>
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<tr>
<td>Canada</td>
<td>23.2</td>
</tr>
<tr>
<td>New Zealand</td>
<td>23.8</td>
</tr>
<tr>
<td>Netherlands</td>
<td>25.2</td>
</tr>
<tr>
<td>U.S.</td>
<td>25.5</td>
</tr>
<tr>
<td>U.K.</td>
<td>26.3</td>
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</table>

Source: OECD Health Care Quality Indicators Project, 2009
Note: Short LOS may cause understatement of US in-hospital fatality rate.
Foreign Body Left in During Procedure

Rate per 100,000 procedures

- Sweden: 0.2
- U.K.: 0.5
- Germany: 0.5
- Canada: 0.7
- New Zealand: 0.9
- U.S.: 0.9

Source: OECD Health Care Quality Indicators Project, 2009
U.S. Now Worst on Preventable Deaths

Source: Health Aff 2008: 27(1):58 and on-line 9/12/11
46 million uninsured Americans is a national disgrace
Number of Uninsured Americans 1976-2010

Source: Himmelstein, Woolhandler - Tabulation from CPS & NHIS Data
Figure 4

Uninsured Rates Among the Nonelderly by State, 2012

- <14% Uninsured (13 states and DC)
- 14-18% Uninsured (20 states)
- >18% percent (17 states)

SOURCE: KCMU/Urban Institute analysis of 2013 ASEC Supplement to the CPS.
The Question then becomes...

Do the uninsured or under insured truly suffer from poorer health outcomes by not readily accessing medical care when they need it?
Patients with High Deductibles Forego Needed Care

![Graph showing the percent of patients delaying or avoiding care due to cost, categorized by low and high deductibles. The graph indicates that patients with high deductibles are more likely to delay or avoid care.](image)

Source: Commonwealth Fund/EBRI Survey 3/08

BOCA RATON REGIONAL HOSPITAL
5-Year Cancer Survival

• Colorectal cancer: 63% for privately insured but 49% for the uninsured

• Breast cancer: 85% for those with private insurance, 75% for the uninsured
Uninsured and Under-Insured Delay Seeking Care for Heart Attacks

Odds ratio for delayed care*

<table>
<thead>
<tr>
<th>Category</th>
<th>Odds Ratio</th>
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<tbody>
<tr>
<td>Insured</td>
<td>1</td>
</tr>
<tr>
<td>Under-Insured</td>
<td>1.21</td>
</tr>
<tr>
<td>Uninsured</td>
<td>1.38</td>
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Source: JAMA April 15, 2010:303:1392
*Adjusted for age, sex, race, clinical characteristics, health status, social/psych factors, urban/rural
Under-insured = Had coverage but patient concerned about cost
Does being uninsured matter?

45,000 adult deaths/year

Underinsurance

- 62% of personal bankruptcies due to medical expenses (2007)
- 78% of people with medical bankruptcies had health insurance when they got sick

“Medical impoverishment, although common in poor nations, is almost unheard of in wealthy countries other than the US.”

Himmelstein et al, American Journal of Medicine, June 4, 2009
Why Health Care Reform Occurred

• Costs
  - Unaffordable to Individuals
  - Excessive Growth in Overall Costs

• Quality & Safety Concerns
  - Uneven & Inconsistent
  - Disparities in Outcomes
  - Preventable Medical Errors

• Access
  - Rising Uninsured/Underinsured Population
  - Decreasing Provider Availability

• Inadequate Use of Health IT
  - Clinical Information
  - Program Management

• Sickness vs. Wellness
  - Primary Focus on Disease...Not Wellness
  - Under- investment in Public Health
Health System Reform

• Provide health care coverage for all
• Improve quality
• Promote wellness and prevention
• Reform public programs
• Reform health care delivery systems
• Reduce cost and increase value
Patient Protection and Affordable Care Act

Two bills enacted in March 2010

• PPACA: March 23, 2010
• Health Care Education Reconciliation Act of 2010: March 30, 2010
  • Amended some PPACA Provisions
  • Upheld by Supreme Court 2010
What the PPACA Has Done in a Nutshell

• Provide a mechanism whereby 40 million Americans who are uninsured today can access healthcare
  • Medicaid Expansion
  • Healthcare Exchanges

• Eliminate pre-existent medical issues as a barrier to obtain health care coverage

• Allow for all bonafide evidence based preventative measures to be provided for Americans at not cost (Pap, Mammogram, Vaccines, Colonoscopy, etc.)
What the PPACA Has Done in a Nutshell, cont’d.

• Limits the profit of payers and dollars not truly going to healthcare. Medical loss ratios capped at 80/85% medium/large

• Requests the public reporting of fully transparent quality and patient satisfaction data
What the PPACA Has Done in a Nutshell, cont’d.

MOST IMPORTANTLY:

• Evolve the healthcare system into one structured around bundled payments where care for individuals are prepaid and governed by strictly enforced core quality, patient outcome measures, and patient satisfaction

• Payments will not be focused on not how much one does, but rather how much one does well
SO WHERE ARE WE TODAY?
2013

• Medicaid programs began to increase coverage of preventative services

• Federal government offered 1% increase in matching payments if states cover certain immunizations and preventative services without charging Medicaid beneficiaries and share the cost (vision not yet included but expectation is there)
2013, Cont’d.

• Medicaid PCPs to be paid Medicare rates through December 31, 2014
• Threshold for itemized deductions goes from 7.5% to 10% of adjusted gross income
• Flexible spending cap drops from $5000 to $2500
• Medicare Tax increase
2014 What is Coming

• Prohibition of discrimination based on gender or preexisting conditions
• Coverage of patients in clinical trials no longer suspended
• Increase access to Medicaid
  • Up to 133% of Federal Poverty Level
  • $14,000/year individual
  • $29,000/year family of four
• Healthcare Exchanges for individuals with income up to 400% of Federal Poverty Level but not eligible for Medicaid → Tax Credits
  • $46,000 for individual
  • $92,000 for family of four
Medicaid Expansion

• PPACA requires participating states to cover nearly everyone under the age of 65 before 133% at Federal Poverty Level

• Federal Coverage Matching
  • 100% - Years 1-3
  • 95% - Year 4
  • 94% - year 5
  • 93% - year 6
  • 90% - year 7 and beyond
Medicaid Expansion, cont’d.

• 17 Million new Medicaid eligible uninsured Americans would qualify

• Total Medicaid participants almost 90 million

• 60% of Medicaid is managed medical today → will likely increase
States and the Expansion of Medicaid

To Date, 20 States & DC Plan to Expand Medicaid Eligibility, 14 Will Not Expand, and the Remainder Are Undecided

State Commitment to Expand Medicaid Eligibility

Source: Avalere State Reform Insights, Updated May 2, 2013
*AR is proposing to use Medicaid funds to pay for premium assistance through exchanges, pending federal approval; TN has reached out to the federal government to consider a similar approach.
Healthcare Exchanges

- October 1, 2013 – Open enrollment began
- January 1, 2014 – Health coverage started
- March 31, 2014 – Open enrollment ends
Healthcare Exchanges, cont’d.

• One stop shop for uninsured (state, Federal, both)
• Easy to compare plans
• Benefits likely to be used
• Large new bolus of patients for providers
• Preventative measures stressed
What Must the Plans Cover?

- Ambulatory patient services (outpatient services)
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including oral and vision care
Accountable Care Organizations (ACOs)
What is an ACO?

• An organization of health care providers that agrees to be accountable for the quality, cost and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.

• For ACO purposes, “assigned” means to those beneficiaries for whom the professionals in the ACO provide the bulk of primary care services.

• Assignment will be invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctor.

• A beneficiary may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is a part of an ACO.
Proposed Quality Measures

CMS Proposes 65 measures in 5 key domains to serve as the basis for assessing and rewarding ACOs:

• Patient/Caregiver Experience
• Care Coordination
• Patient Safety
• Preventive Health
• At – Risk Population/Frail Elderly Health
Medicare ACOs Operational in Many States

Source: CMS press releases and fact sheets
The Paradigm Shift

• **Payers** - As medical-loss ratios capped at 80 to 85%, insurers will focus on locking in their profit or passing off the remaining risk to providers

• **Providers** - Will finally learn to coexist synergistically (hospitals, physicians, post acute care) as for the first time they will all sit on the same side of the table - Quality and cost efficiency will be the keys to a brave new and even profitable health care world

• **Patients** - Finally health care will be patient centric but they will be active participants in their care through their wallets
Medicare

- 37 Million members growing at unprecedented rate of 10,000 baby boomers per day
- FFS Model → bundled payment model
- ACO/Managed Care
- More and more new Medicare participants will be living on fixed income → likely to choose ACO managed model
- Vision care most likely to become a sustained fixed benefit
Medicare, cont’d.

• High quality cost effective care will drive this benefit

• Robust IT systems will be needed to accomplish transparency

• Vision/dental care will almost certainly evolve into a risk sharing model, much as is mainstream medicine

• ECP network willing to accept risk will have opportunity to capture market share

• Supply chain of high quality, low cost finished eyewear will be crucial for cost containment and quality requirements
Medicaid

- Vision benefit including eye exam and finished eyewear is a benefit in most plans today
- Most Medicaid today is in a managed network and that number will likely increase to > 90% over time
- Absolute number of Medicaid participants will soon become 1 in three Americans
- PM/PM dollars allocated to vision care benefits likely to ratchet down over time
- Utilization will likely increase as preventative measures encouraged and use of today’s LED devices increases exponentially

Those willing to accept risk will become market leaders
New pediatric vision benefit likely to be highly used

Employer sponsor plans likely will look for low cost, high quality network in order to stretch health care dollar
The Bottom Line

• Most rapid growth in optical/industry will occur in the Entitlement programs
• Absolute patient numbers and utilization will increase by virtue of new growth in Medicare members, Medicaid members and those commercial members who will have the pediatric vision benefit
• Dollars funding these programs would be expected to contract as health care economics cannot keep pace with utilization
• As margins erode, cost effective strategies now mainstream in traditional medicine will penetrate into the optical world (e.g. Risk Programs)
Opportunity for the Optical World