How to Achieve Success in a Consumer Driven Healthcare Environment

Provider Strategies in 2007 and Beyond

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Preferred Health Strategies

How did we get here?

- Before we address the specifics of Consumer Driven Healthcare, we should all be clear on what has brought us to this point and what is at stake
- Within the last 70 years we have gone from a nation with limited health insurance coverage to one that is largely insured through employer-based and public health insurance programs
- At the same time that our access to health care has seemingly increased (albeit there are still 47 million uninsured), there are a number of trends occurring simultaneously which are placing the future of our health care system in serious jeopardy

What are these trends?

- First, population growth: the population increased from 123 million people in 1930 to over 300 million people in 2006 - taken by itself this would place a significant strain on the system
- But there is more: the growth in the population has not been evenly distributed: there are about 80 million baby boomers who will begin entering the Medicare program in 2008
- Within the next 10 to 15 years, retirees will outnumber workers/taxpayers casting serious doubt over the long term viability of the Medicare program

What are these trends?

- The private health insurance market is not faring any better: private health insurance accounts for the largest single component of the nation's health care bill, or over 36% of the total. Since 1980, private health insurance costs have increased by over 900%
- Total health expenditures are now in excess of $2.2 trillion or over $5 billion a day and CMS projects that health costs will double to over $4 trillion by the year 2015
- According to the same estimates, health care will represent 20% of the GDP in 2015, a 25% increase in only 10 years

What are these trends?

- The average annual premium that an insurer charged an employer for a family of four was $11,500 in 2006; that compares to annual wages of only $10,712 for a minimum wage employee
- Health benefits accounted for over 42% of all benefit spending by employers in 2003 compared to only 14% in 1960 and is now the fastest growing benefit category

What are these trends?

- Since 2000, employment based premiums have increased 87% compared to a cumulative wage growth of only 20%
- According to an analysis by McKinsey and Company*, unless something changes dramatically, ***health insurance costs will overtake profits by 2008***

McKinsey and Company. The McKinsey Quarterly Chart Focus Newsletter, "Will Health Benefit Costs Eclipse Profits," September, 2004

How does this relate to CDHC?

- So what does this all mean and how does it relate to CDHC?
- CDHC is an attempt to address the issues of a health care system that is spiraling out of control on all fronts:
  - Volume - due to increases in the population and access
  - Unit cost - due to technology and inability to control utilization to any significant extent
  - Demand - due to increased consumer knowledge (thanks in some part to the internet and consumer advertising) and desire for access to the latest in technology and services that are currently available without limitation and without regard to price

How does this relate to CDHC?

- Consumer Driven Healthcare is viewed as a way to arm the consumer with both the knowledge (transparency, pay-4-performance) and the incentive (high deductibles, savings vs. spending opportunities, and tiering) to make rational decisions on the use of health care services

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Is CDHC gaining momentum?

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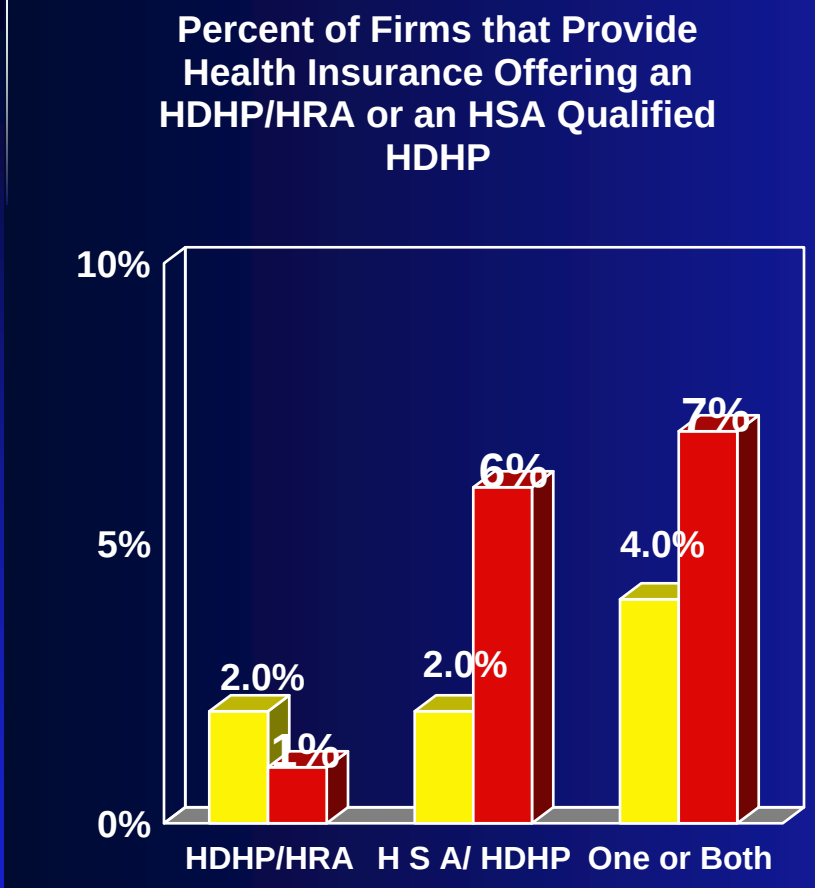
Employer Trends



Source: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2006

- In 2006, there were 1.3 million covered workers in a High Deductible Health Plan (HDHP) HRA and 1.4 million covered workers in an H S A qualified HDHP
- The percentage of firms offering either an HDHP H S A or HRA increased from 4% to 7%, although the difference was not statistically significant

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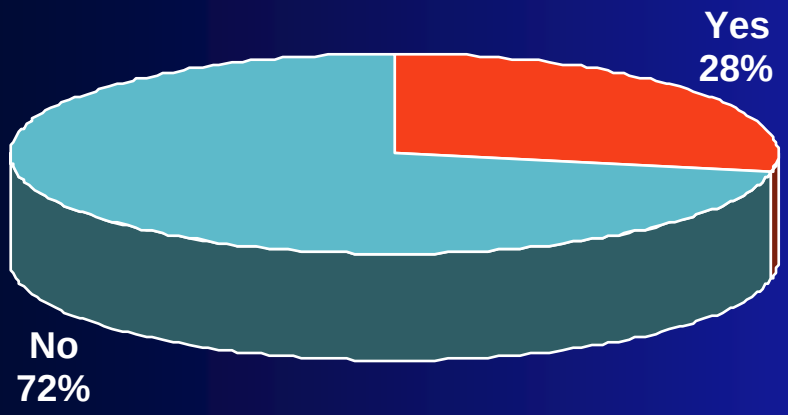
Employer Trends

Does your employer offer a consumer driven health plan option?



Source: Aon Consulting/ISCEBS Survey
June 2006

- According to a recent survey, 28% of employers now offer a consumer driven health plan option, up from 22% last year
- 75% of employers with a CDHP began offering the option in 2005 or 2006
- Employers are offering these plans to help control rising costs (38%) and to introduce "consumerism" into the purchasing of health care (48%)
- 30% of employers believe the concept is too new and have adopted a "wait and see" attitude

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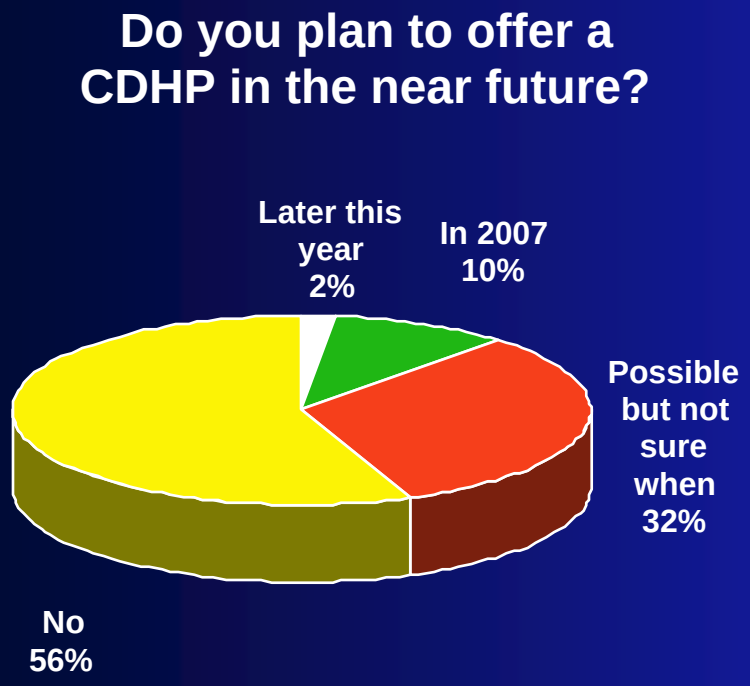
Employer Trends



Source: Aon Consulting/ISCEBS Survey June 2006

- Of those employers that do not currently have a CDHP option, 44% are considering it
- Of those employers considering CDHP, 29% are thinking about offering an HSA as an option and 5% are considering it as a total replacement for their existing health plans
- Only 16% are considering an HRA

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Payer Trends

- Most insurers now have at least one consumer directed product as one of the options for employers/employees, including:
  - Aetna
  - UnitedHealthCare
  - Anthem/Wellpoint
  - Cigna
  - Blue Cross/Blue Shield
- Specialty vendors are also offering CDH products directly to employers
  - Destiny
  - Lumenos
  - Vivius

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Survey Says…..

According to the 2nd annual EBRI/Commonwealth Fund Consumerism in Health Care Survey for 2006:

- Enrollment in CDHPs and HDHPs was virtually unchanged between 2005 and 2006. Only 1% of the privately insured population or 1.3 million individuals are enrolled in these plans; another 8.5 million are enrolled in plans with deductibles high enough to qualify for a health savings account but they do not have such an account
- Impact on the uninsured appears to be negligible. Enrollees in CDHPs are no more likely to have been uninsured prior to enrollment than individuals in traditional plans
- As in 2005, enrollees in CDHPs and HDHPs continue to be less satisfied with their health plan than traditional enrollees and less likely to recommend it to a friend

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Survey Says…..

- More than half of CDHP enrollees are in plans in which the deductible applies to all services including preventive care
- Individuals in CDHPs and HDHPs are more likely to delay or avoid care because of the cost than enrollees in traditional plans
- CDHP and HDHP enrollees exhibit more cost-conscious behavior in health care decision-making than their traditional enrollee counterparts (but both report such behavior)
- People in CDHPs and HDHPs were less likely to report that their health plan provided information on the cost and quality of care

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Does it work?

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- The jury is still out
- From the consumers perspective, the reaction is mixed
  - According to the EBRI/Commonwealth Fund survey, 63% of individuals with comprehensive health insurance are extremely or very satisfied with their health plan compared with only 42% of CDHP enrollees and 33% of high deductible health plan enrollees
  - Individuals with CDHPs (35%) and HDHPs (31%) were significantly more likely to avoid,skip or delay health care because of costs than their counterparts in comprehensive health plans (17%)
  - Other more recent surveys*, however, have reported much higher consumer satisfaction rates, in the 90% range

*Source: Aon Consulting/ ISCEBS Survey June 2006

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- From the employer and the payer's perspectives, it may be too soon to tell, although there have been both encouraging and discouraging signs over the past year
- There have been some reports that CDHPs have begun to encourage healthy behaviors and curb double-digit premium increases
  - A three year Humana study of 13,000 employees found that an increased use of preventive services among the CDHP enrollees led to fewer medical interventions and annual claim cost increases of 5-6% vs. double digit increases for enrollees in the traditional plans

Source: Kaiser Daily Health Report, June 13, 2006

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- Other studies have been much more negative, questioning the very premise on which consumer driven health care rests (i.e. making consumers more sensitive to the cost of health care)
- According to a recent study just published in Health Affairs, high deductible health plans actually reduce cost-sharing for people at the extremes (i.e.those who spend the least and the most amount on health care)
- Specifically, patients who account for half of all medical spending in this country (7.7% of the population) would see no change or a decline in their cost-sharing under an high deductible/HSA

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- Because HSAs are shielded from federal and state income taxes and payroll taxes, consumers receive a subsidy with which they can purchase health care, resulting in a lower overall out-of-pocket cost
- The only way to address this issue is to increase cost-sharing for the highest users of care but this would mean making health care unaffordable for those who need it most

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- So what does this have to do with tiering, pay 4 performance and provider networks?

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Tiering

- Tiered provider networks are often used in conjunction with CDHPs as a way of enabling consumers to differentiate among providers on the basis of quality, cost and satisfaction
- Under this type of arrangement, enrollees pay different cost-sharing rates depending on what tier the provider is in-
  - Tiers are assigned on the basis of cost and/or quality
  - Patients make a point-of-service decision on what provider to see based on the copays as well information provided to them on price and quality

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Tiering

- Milliman's annual survey of HMOs and PPOs indicated that 17% of healthplans offered a tiered product in 2004 and 42% expected to offer one in 2005
- Some of the larger payers with tiered products include PacifiCare, Premara Blue Cross, HealthPartners in Minnesota, Tufts Health Plan and Aetna
- Blue Shield of California introduced Network Choice in 2002 and is now one of the largest hospital tiering programs in the country

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Tiering

- Tiering Strategies:
  - Hospital tiering - easier to implement

  Vs.
  - Physican tiering - targets the real drivers of health care utilization
- Many view tiering of physicians as much more complex and have focused initially on hospitals
- Some plans like Tufts started with a hospital tiering program and are now introducing physician tiering as well
- Many payers also use benefit tiering to steer patients to specific providers

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Hospital Tiering

- Some hospital tiering models compare all hospitals within a geographic market, regardless of the type of hospital
- Tufts Health Plan, for example, incents its members to use community hospitals whenever possible by placing the academic medical centers in a premium tier and the community hospitals in a core tier
- Other plans, such as Blue Shield in California created tiers *within* the academic medical centers and separate tiers among the community hospitals

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Hospital Tiering

- Some plans use a two-tier structure (e.g. Blue Shield of California) while others use three tiers (e.g. Blue Cross and Blue Shield of Florida, Premera Blue Cross)
- Almost all plans use both cost and quality measures to establish the tiers
- Cost indicators may be based on negotiated rates or on more sophisticated analyses of claims data to determine case-mix adjusted average costs

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Hospital Tiering

- Quality indicators may be based on measures developed by organizations such as Leapfrog, JCAHO or internal data and patient satisfaction surveys
- Ideally the measures are transparent so that they are easily understood by providers and patients

Outlook for Tiering

- It's achieving mixed reviews
- Some believe tiering will ultimately replace PPOs (full consumer choice vs. limited network)
- Others believe tiering is too complex for consumers
- It is still too soon to determine the impact of tiering on costs although some health plans have reported reductions in premium costs
  - Premara estimates a 10% reduction
  - PacifiCare estimates a 15% savings

Outlook for Tiering

- In many cases, the hidden agenda behind tiering is the pressure it creates for providers to agree to a larger discount in exchange for placement in a more favorable tier
- In some cases, the cost incentive is “built-in” to the product design
- This is completely analogous to the impact of tiered prescription products on the price of pharmaceuticals - pharmaceutical companies have become very adept at agreeing to larger discounts and rebates in return for placement on a preferred tier

Tiering Contracting Issues

- Managed care plans will try to incorporate language into the contract that will enable the plan to tier the provider on the basis of cost and quality
- As part of your negotiating strategy, **RESIST**
- Propose language that specifically *precludes* tiering
- Academic medical centers may want to consider tiering on the basis of costs as a deal breaker

Pay 4 Performance

- What is Pay 4 Performance?

  any performance-based provider payment arrangements including those that target performance on cost measures

- Pay 4 Performance is not a new concept; health plans have been evaluating physicians and including “quality” based payments in their reimbursement for years
- There are currently over 100 pay 4 performance programs nationwide*
- Medicare and Medicaid are also experimenting with pay 4 performance programs

*Source: Pay for Performance: A Decision Guide for Purchasers; AHRQ, US Dept. of HHS, April 2006

Pay 4 Performance

- Besides the obvious issue of cost, what is driving the resurgence of interest in these programs?
  - 1999 - IOM Report “To Err is Human” documents up to 98,000 deaths annually from medical error
  - 2001 - IOM Study “Crossing the Quality Chasm” reports on the gap between optimal care and actual care, the difficulty in managing chronic care conditions and the health care systems lack of organization and continuity of care
  - 2003 - Rand study finding the optimal care is delivered only about 55% of the time

Pay 4 Performance

- Examples of Pay 4 Performance programs
  - Bridges to Excellence (BTE) - initially developed by employers to incentivize physicians to adopt better care processes
  - Health insurers now licensed to offer BTE programs
    - Physician office link - rewards physicians for office practice use of information to improve patient care
    - Diabetes Care link - reward physicians based on improvement in quality of care for diabetes patients
    - Cardiac Care link - rewards physicians for improvements in quality of care provided to patients with cardiovascular disease

Pay 4 Performance

- Examples of pay 4 performance programs
  - Leapfrog started by a group of large employes in 1998
  - Leapfrog's Hospital Rewards program focuses on five conditions (AMI, CABG, PCI, CAP, Newborns)
  - Measures both quality and efficiency
  - Uses relative benchmarks to assess hospital performance
  - Rewards both improvement and top performance
  - Based on shared savings model

Pay 4 Performance

- Examples of pay 4 performance programs
  - PROMETHEUS (Provider payment reform for outcomes, margins, evidence, transparency, hassle reduction, excellence, understandability and sustainability)
  - Developed by a not for profit corporation, PROMETHEUS is a payment model designed to improve quality, lower administrative burden, enhance transparency and support a patient-centric and consumer driven environment
  - Based on an Evidence-based Case Rate (ECR) with additional performance incentives

Pay 4 Performance Contracting Issues

- Managed care plans will look to include Pay 4 Performance provisions in their contracts as a *reduction* in the fee schedule if targets are not met
- Providers need to argue for ‘add-on’ payments during contract negotiations
- Providers also need to be sure that the methodology is clearly articulated and that the plan is capable of implementing the Pay 4 Performance provisions

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So How are Providers Reacting?

- Many are reacting in the time-honored way by sticking their head in the sand and saying it won't happen *or* it won't happen here *or* if it happens here it won't happen to me - *So let's not do anything until after it's here*
- Unfortunately, most of the pieces needed for consumer driven health care to succeed are already here and in place

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So what strategies are the providers adopting in their relationships with the health plans?

Provider Strategies

- Short-term strategies:
  - Savvy providers are trying to get the doctors and the hospitals on the same page, integrated and mutually dependent
  - They are developing staged managed care contracting strategies:
    - More aggressive pricing on tighter, more highly controlled DRGs for payers with significant patient volume
    - Less aggressive for payers that account for more limited volume and with case loads that more unpredictable in terms of cost

Provider Strategies

- Providers need to develop strategies designed to deal with the practical implications of CDHC, including the need for:
  - financial strategies to absorb increases in bad debt as consumers are faced with bills they can't pay
  - more collection resources
  - more accurate patient-liability estimates at the time of service or inquiry
  - Greater emphasis on cost and quality data

Strategies Providers Should be Developing

- Long-term strategies:
  - Cost reengineering - providers are beginning to develop meaningful clinical pathways that define the protocols and services by diagnosis
  - They will have to invest in cost accounting and clinical information systems that provide them with the data needed to identify costs, streamline the process and improve quality

Strategies Providers Should be Developing

NOTE: None of this can accomplished without a first rate IT platform - Providers and health plans need to focus on information rather than bricks and mortar!

Closing Thoughts

- The health plans are consolidating and many of them, even the Blues, now have shareholders to satisfy
- Employers are funding increases in health care from their bottom lines and they've about reached bottom - some form of CDHC is likely to remain in place for the near future
- Whatever solution ultimately takes hold, one thing is certain - patients will continue to be armed with information, good and bad, and are going to be shopping around for the best service at the best price
- The providers that will survive will be those that invest the time and the resources to improve both process and outcome and figure out how to communicate that to their various publics