



The Convergence of P4P & CDHC

February 16, 2007

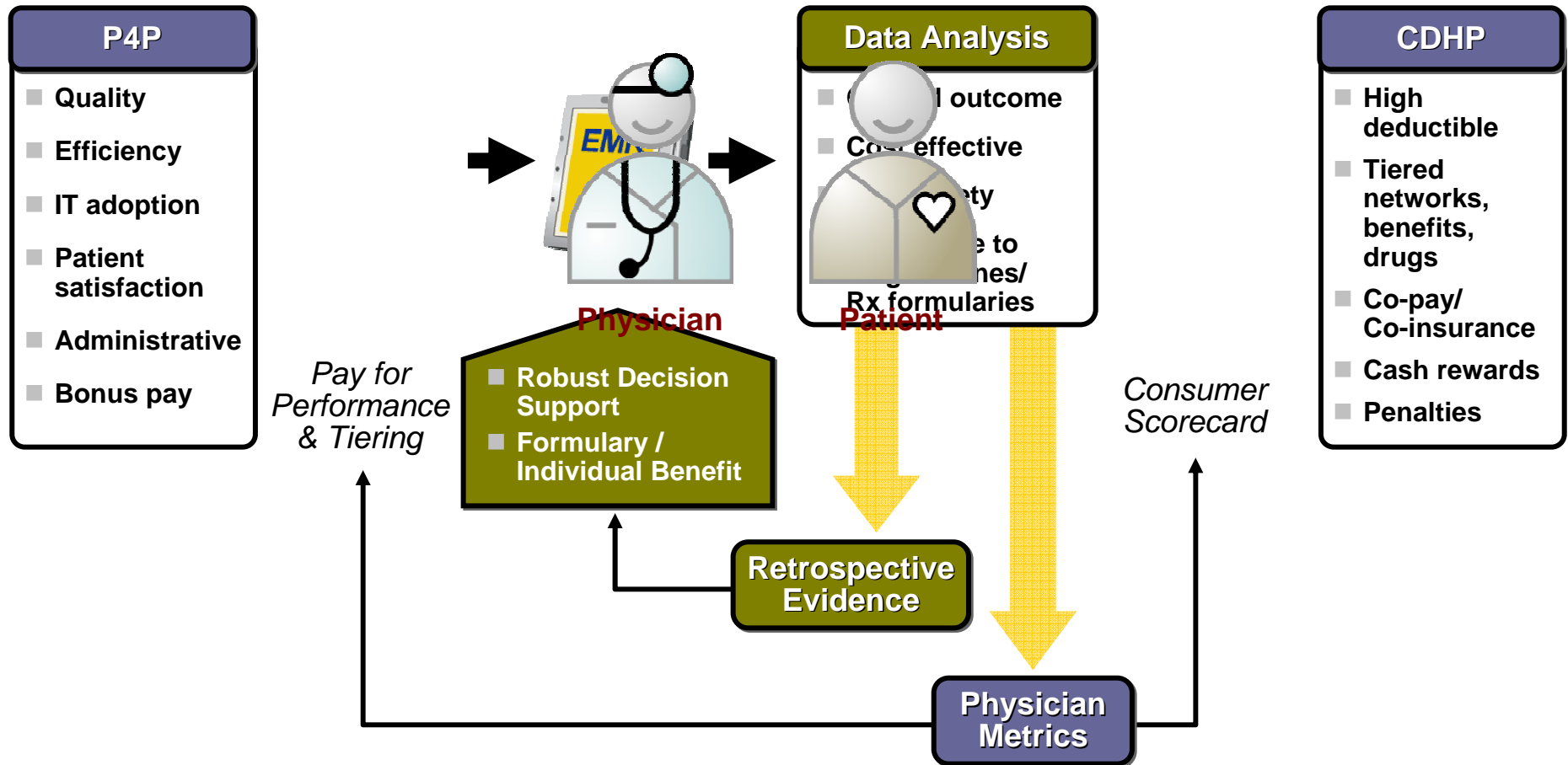
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Health Strategy

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New Structural and Incentive Programs Are Poised to Impact the Physician/Patient Relationship



Working Definitions

Pay for Performance (P4P)

- A program under which payors or plans retrospectively compensate providers based on achievement of pre-defined measures
- Driven by both commercial and federal government efforts to gain predictability and control of healthcare utilization
- For the Federal government, an attempt to address the failure of SGR and past Medicare reimbursement schemes to rein in the unpredictability and upward trend of healthcare costs

Consumer Directed Health Plan (CDHP)

- A health plan with three common characteristics:
 - ◆ High deductible (HDHP)
 - ◆ An associated tax-advantaged savings account to pay for medical expenses under the deductible (HRA/ HSA)
 - ◆ Decision support tools to guide consumer decision-making (still nascent)



Mechanisms to Achieve Objectives

The two mechanisms assume different sources of high costs and are directed at achieving their objectives by applying leverage at two different participants in the healthcare transaction

Consumer Directed Health Plans

- Addresses **over-utilization** of health services by increasing the financial impact of consumer health care decision-making and behaviors (and risks)

Consumer will drive

Lower Cost

Paying for Performance

- Creates incentives for increased compliance with evidence based practice, particularly addressing **under-utilization** of preventive and related services

Provider will drive

Improved Quality,
Leading to
Lower Costs

Underlying Factors Driving Trends

- Double-digit health care inflation
- Inadequate use and compliance with evidenced-based medicine
- Emerging development of health IT infrastructure and standardization of cost and quality metrics



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Working Hypothesis

Current Impact is Minimal

- CDHP enrollment is growing, but is limited to generally healthy individuals
- Despite over 100 active programs covering more than 53 million Americans, P4P programs currently unable to assess overall quality of care

Incentives and Overall Intent Do Not Match Up

- Traditional physician payment based on volume of patients and services, creating an incentive to order more tests and services
- P4P may focus physicians more on measures rather than need and exacerbate this situation
- P4P measure may require additional patient office visits versus the consumer who needs to manage a more limited CDHP budget

Patient-Physician Relationship in Jeopardy

- The dialogue between patient and physician is a dynamic one that constantly negotiates and renegotiates treatments
- Introducing financial gain conflict and focus on reporting doesn't address the fundamental problems of coordination of care across multiple providers or appropriateness of medical utilization



Key Trends Driving Development Of CDHP And P4P

Desire of purchasers to stem costs, coupled with a growing population of empowered consumers demanding more choice, are driving the development of both CDHP and P4P products.

Desire of Purchasers to Mitigate Costs

- Both P4P and CDHP developed out of the erosion of the managed care model, as employers placed pressure on plans for new models to reduce costs and achieve quantifiable outcomes.

Emergence of Consumers as Directors of Care

- There is an emerging segment of consumers who are empowered and feel comfortable being the directors of their care and care coordination.
- This segment is comfortable making decisions about cost/quality trade-offs, and desires access to better information that will make decision-making easier (e.g., cost data, physician evaluation data).

Underlying Demographic & Employment Trends

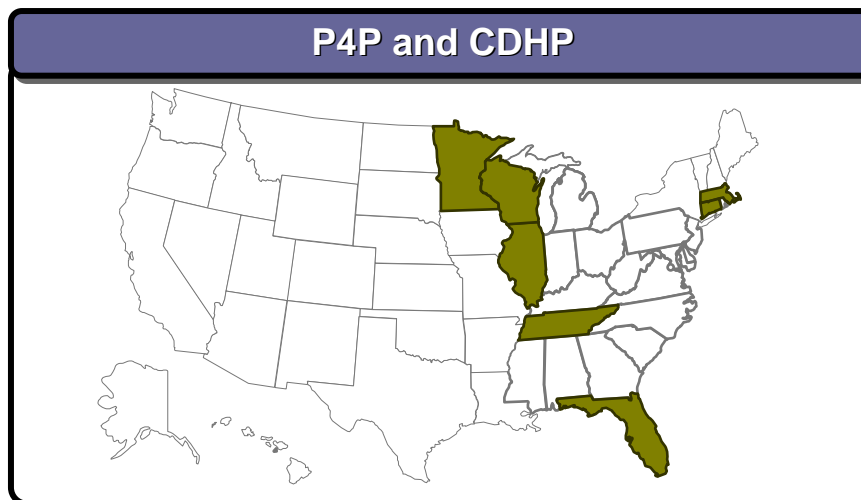
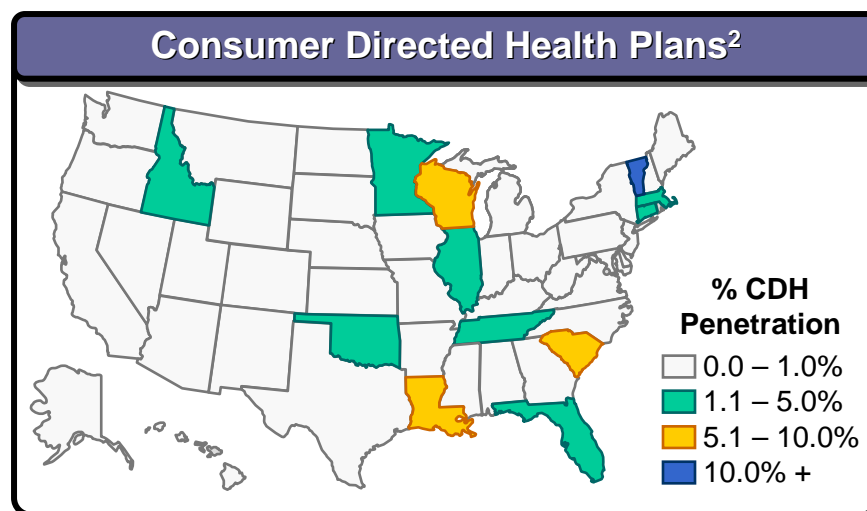
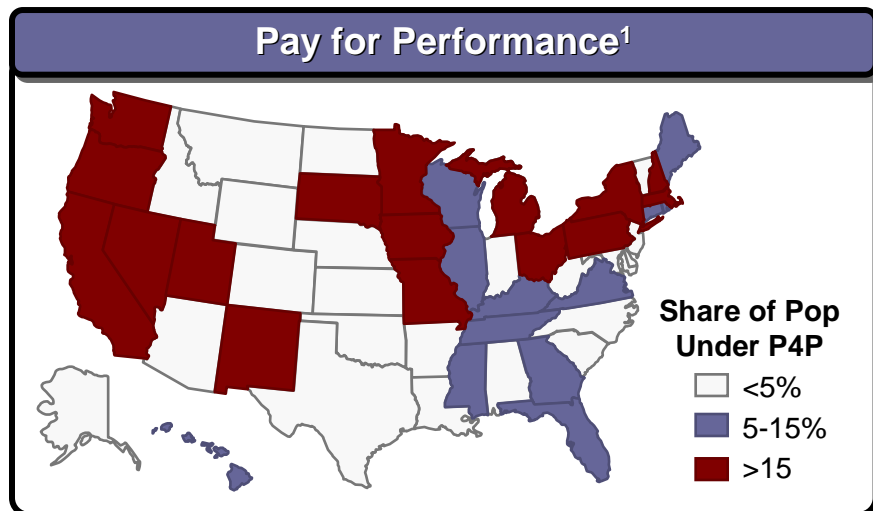
- Younger generation more mobile, and are more likely to move geographically as well as change jobs more frequently.
- Such underlying trends create a need for more portable coverage.

Convergence Of Health Insurance And Financial Security

- Shift in recent years to greater levels of cost sharing (irrespective of CDHPs) have generated consumer recognition that “health” and “wealth” are linked.
- Early adopters of CDHPs view product as a wealth accumulation and management tool, rather than just a health insurance plan.



Penetration of Programs by State



Sources:

¹ HealthAce Data, 2006; ² AIS Directory of Health Plans, 2006. Note: Total CDH Enrollment/Total HMO, PPO, POS enrollment (Excludes Medicaid and other public coverage, Medicare, and self-insured figures); ³



The Hoped Evolution of Pay for Performance

P4P May Evolve to Address More Comprehensive Measures of Care and Efficiency, and Assess Overall Performance

Current State Characteristics

- Addresses underuse of preventive services
- Uses basic process measures as proxy for quality of care
- Emerging use of metrics to target efficiency
- Focus on primary care
- Reliance on administrative data for measurement
- Physicians paid a percentage above the fee schedule

Weaknesses Addressed

- Underlying data, measures, and analysis underdeveloped
- Metrics sensitive to patient characteristics/demographics
- Marginal component of physician compensation
- Fragmentation of designs and reward systems

Future State Characteristics

- Incorporates metrics addressing use across a number of specialties
- Advanced outcomes and cost-effectiveness measures
- Metrics risk-adjusted for patient characteristics/demographics
- Performance payment compensation more significant
- Use of tiered networks to further segment providers
- Measurement based on combination of clinical and administrative data



Projected Detours of Pay-for-Performance

Safety

Transparency

Efficiency

Standards of Care

Evidence-based Guidelines

Process Measures

Pay-for-Reporting

Physician Ranking

Pay-for-Conformance

Gainsharing



NEJM October 2006: Paying for Performance – Five Questions to Ponder

- 1 What is the underlying goal?
 - ◆ Improvement in quality of care or “efficiency”?
 - ◆ How will it answer the question about responsibility for coordinated care?
- 2 Are the measures adequate?
 - ◆ Balance of risk/benefit of individual care across multiple providers?
 - ◆ Technical problems of measurement
- 3 Is implementation feasible?
 - ◆ Data collection / quality of audits
- 4 Will the rewards be sufficient?
 - ◆ Rob from Peter to pay Paul (low performers to subsidize high performers)
 - ◆ Is Medicare going to be able to follow suit with bonuses?
- 5 Could there be unintended consequences?
 - ◆ Risk adjustment not adequately reflected
 - ◆ Misalignment of professional code of conduct
 - ◆ Physicians “opting out” of reimbursement schema

Source: Fisher Elliott S. “Paying for Performance – Risks and Recommendations.” *NEJM*. 2006;355:1845-1847.



The Hoped Evolution of Consumer Directed Health Plans

CDHPs May Increasingly Integrate Additional Designs, Support Tools and Incentives to Further Clarify Cost and Quality Trade-offs

Current State Characteristics

- High deductible health plan coupled with a HRA/ HSA
- Catastrophic coverage above deductible
- Limited first-dollar coverage for services
- Limited information about physician selection and treatment options

Weaknesses Addressed

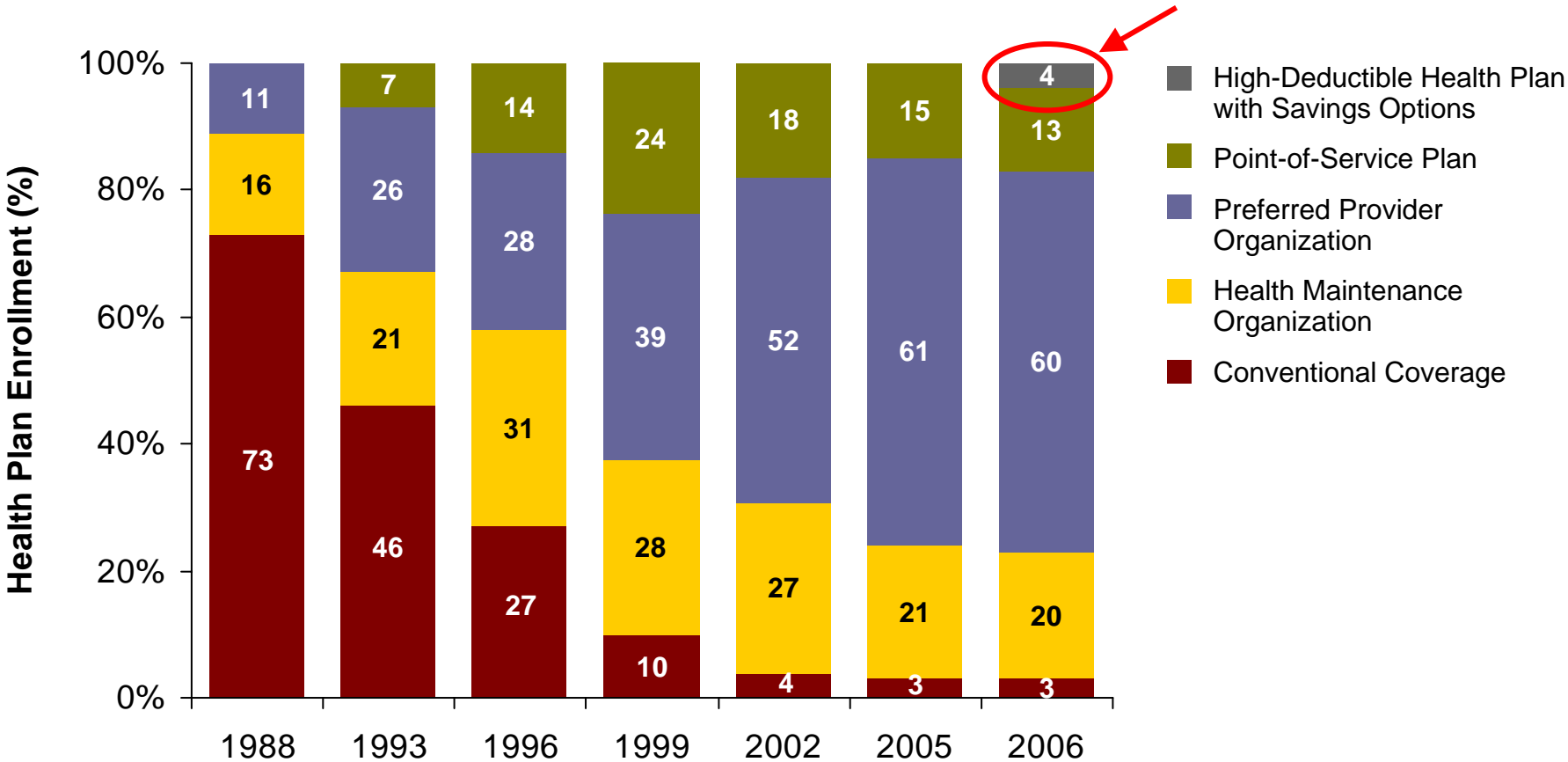
- Crude decision support tools
- “One-size-fits-all” model, attracting niche demographic
- Inability to decipher costs

Future State Characteristics

- Numerous product designs linked to savings accounts
- Segmentation and customization of benefit design and incentives
- Robust decision support tools
- Integrated disease management
- Explicit consumer incentives encouraging compliance
- Availability of comparative cost data
- Use of tiered networks to inform cost/quality decisions



Health Plan Enrollment According to Type of Plan



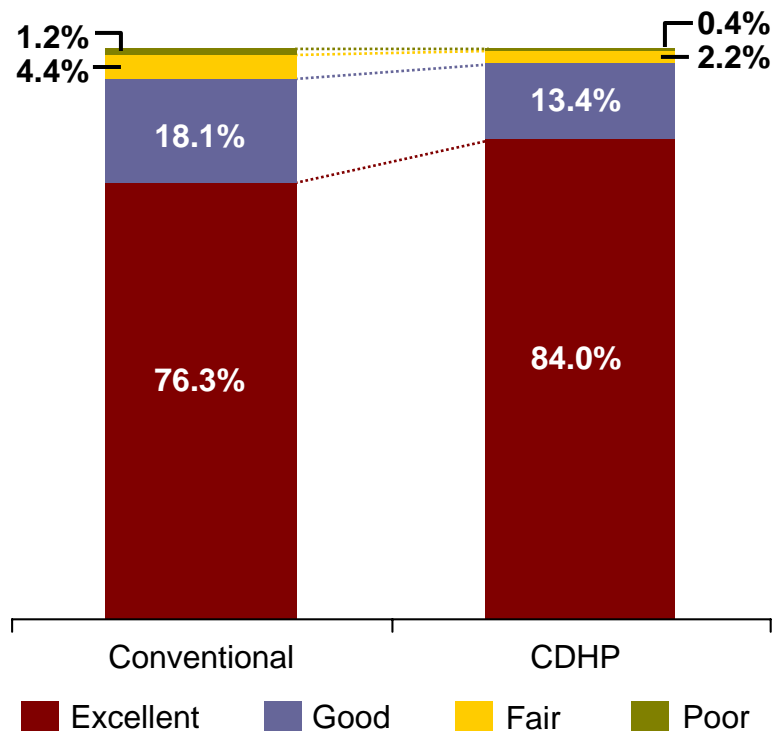
Source: M. G. Bloche. "Consumer-Directed Healthcare." *NEJM*. 2006;355:1757.



Current Demographics of CDHP Enrollees

Currently, CDHP Products Are Attracting Enrollees Who Are More Likely to Report Their Health Status as “Excellent,” and Who Are More Comfortable Making Choices About Their Health Care Treatment

Self-Reported Health Status Conventional vs. CDHP



CDHP Enrollees

- “This joke in our office is that this is the healthy, rich people’s plan.”
- “Because I don’t put myself in a high risk category, it’s a good option.”
- “For me, the largest selling point was that there is no referral required and I can go to any doctor I want.”
- “You are dealing with a more educated population. We ask questions, do research.”

Enrollees in Conventional Products

- “We use health services quite a bit.”
- “I won’t join (a CDHP). It’s much better for healthy people.”
- “I wanted to stick with what I knew.”
- “My employer offers a CDHP and it wasn’t clear to me what was going on, so I stayed in my current plan.”

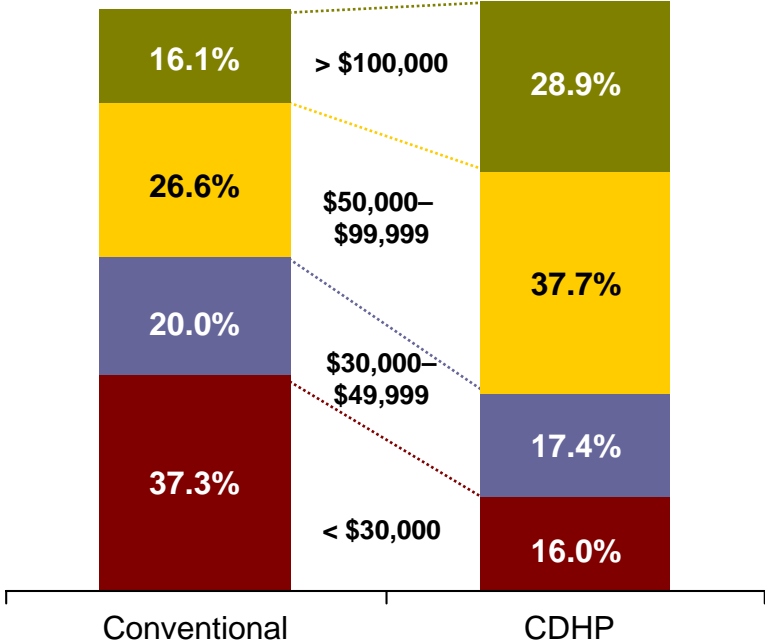
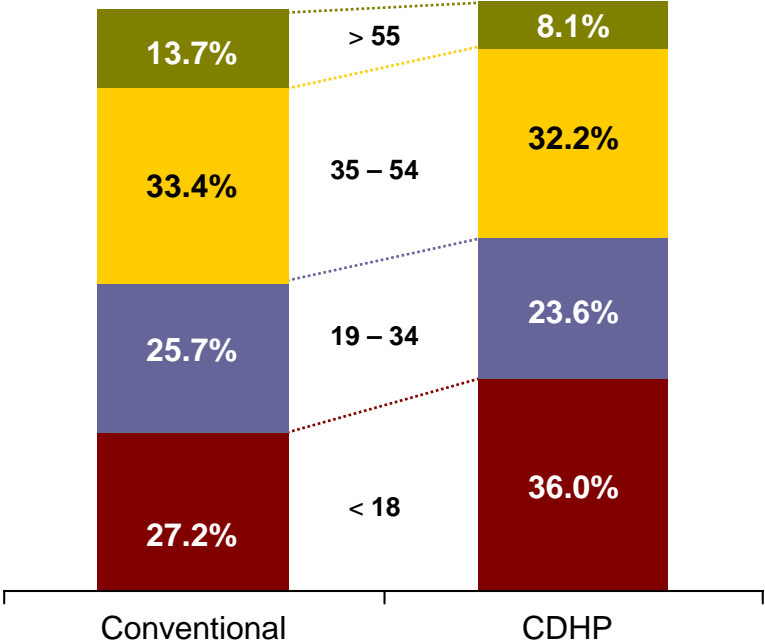
Source: Lewin Health Benefits Simulation Model, Lewin Focus Groups

Current Demographics of CDHP Enrollees

Enrollees in CDHPs Are Also Younger and Tend to Have Higher Incomes Than Those in Conventional Plans

Estimated Age Profile
Conventional vs. CDHP

Estimated Income Profile
Conventional vs. CDHP



Source: Lewin Health Benefits Simulation Model



CDHP Findings

Enrollee/Non-Enrollee Focus Group

Enrollees also appear to be more autonomous, and use plans as a wealth accumulation vehicle while healthy, with the option of switching back into a more traditional plan if needed

- CDHPs viewed as a wealth-accumulation vehicle while healthy
- CDHP enrollees placed more value on autonomy than non-enrollees
- CDHP enrollees will switch back to traditional products if they increase utilization

Designers Interview

Designers of CDHPs are quick to point out that “consumerism” encompasses more than benefit design, and development of next generation products is already underway to mitigate risks associated with “just cost shifting” and prepare for the addition of new enrollees, including those with chronic illnesses

- “Consumerism” encompasses more than benefit design
- No consensus on impact on chronically ill
- Consumer-directed health care predicated on premise that reliable cost/quality data are available



P4P Findings

Physicians Interview

Although there are mixed physician views about P4P, most acknowledge that P4P is here to stay and hope that incentives, measurements, and methodologies improve

- Mixed views among physicians
- Financial rewards are modest
- Financial rewards are not always clear to physicians
- Concern About methods and data underlying P4P scoring

Designers Interview

P4P designers are quick to point out the limitations of current programs and are hopeful about the future

- Reliance on standardized metrics
- Quality measurement constantly evolving
- Limited expansion to small groups/specialists
- Mixed responses on whether P4P achieving objectives



Preliminary Look to Assess whether the Forecasted Conflicts between CDHP and P4P were Bearing Out

Primary Research as the Foundation

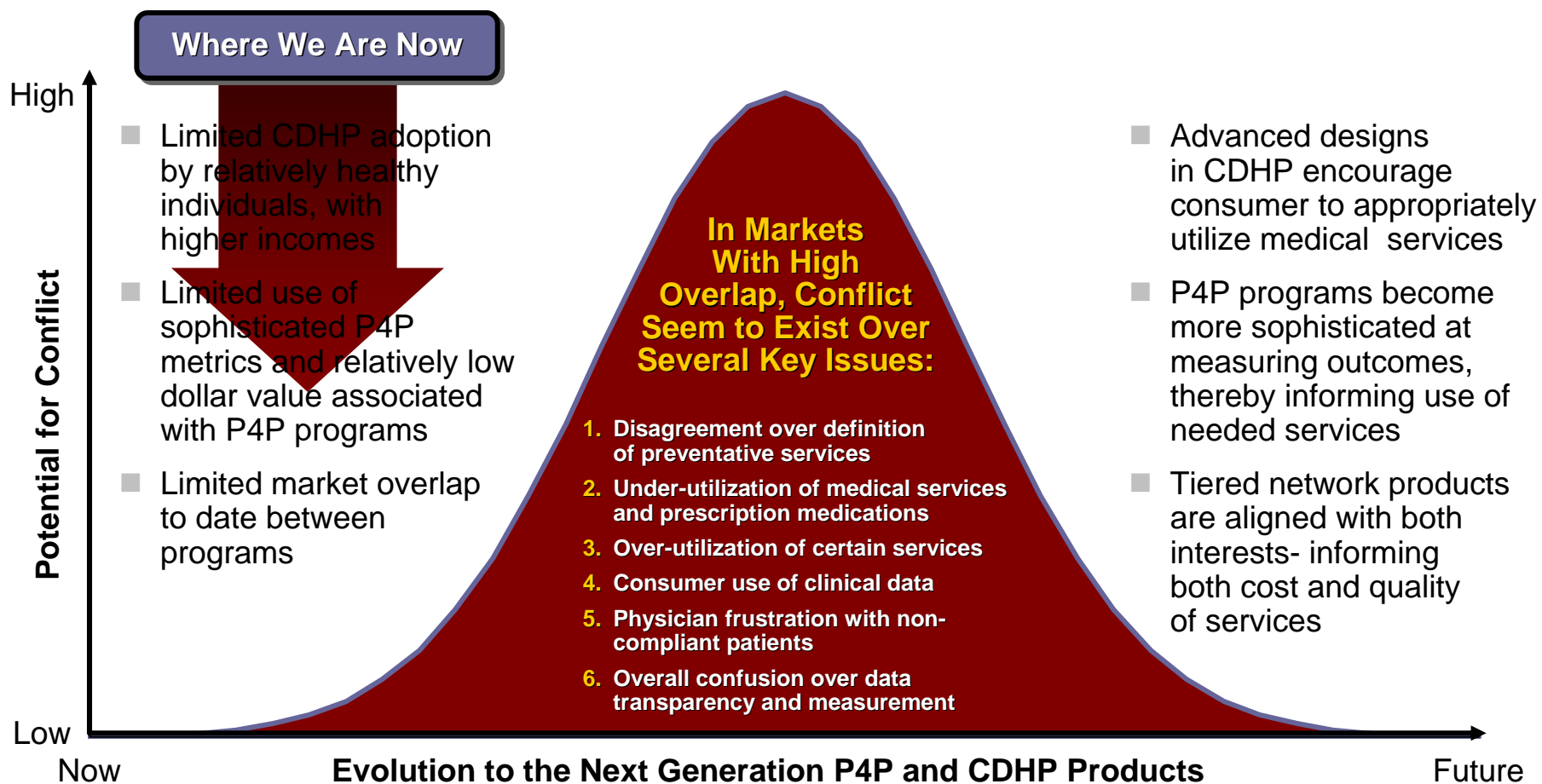
- Findings relied heavily on interviews conducted with three primary groups and two focus groups:
 - ◆ Designers of CDHP programs
 - ◆ Designers of P4P programs
 - ◆ Physicians participating in P4P programs/Physicians declining participation in P4P programs
 - ◆ Enrollees in a CDHP plan (focus group)
 - ◆ Enrollees who declined participation in a CDHP plan (focus group)

Secondary Literature Scan to Support Both Efforts

- Secondary research was used to identify primary research participants and inform questions asked during the primary research
- Secondary research was also used to identify more recent program structures / demographic information of participants in both trends



Sources of Conflict



Note: Analysis assumes geographic overlap between the two trends



Conflict 1: Definition of “Preventive Care”

Conflict	Discussion	Scenario
<p>Disagreement Over Definition of Preventative Coverage</p>	<ul style="list-style-type: none"> ■ Most CDHPs interpret current Treasury Guidance preventative care narrowly, offering coverage for very basic preventive care only (immunizations, OB/ GYN visits, well-child visits, etc). ■ P4P programs tend to encourage adherence to basic preventive care (e.g.- immunizations) as well as compliance with well-established evidenced-based practices, such as beta-blockers post MI, and drug-therapy for lowering LDL cholesterol. ■ Additionally, CDHP enrollees are often confused over what services are, versus are not, subject to first- dollar coverage. ■ Conflict to occur between plan, consumer and physicians as to which level of care is appropriate under first- dollar coverage, especially in light of consumer confusion over preventive care 	<p><i>“If a diabetic needs education and home visits, these all become extra charges that are not paid for in a CDHP (that are preventive).”</i></p> <p style="text-align: right;">– Physician</p> <p><i>“I thought everything was subject to the deductible. It’s not?”</i></p> <p style="text-align: right;">– Consumer</p> <p><i>“ I think if you go for a physical, it’s a co-pay, but if you need tests, then I’m not sure what happens.”</i></p> <p style="text-align: right;">– Consumer</p> <p><i>“I learned drugs weren’t covered after I joined!”</i></p> <p style="text-align: right;">– Consumer</p>



Conflict 1: Definition of “Preventive Care”

Common P4P Measures	Description	Availability of First Dollar Coverage ¹
Mammograms	■ Once a year screening to detect breast cancer	6 of 8 plans cover
Immunizations	■ Immunizations for both adults and children	5 of 8 plans cover
Well-visits	■ Annual exams and well-child visits	8 of 8 plans cover <i>(although co-pay may apply)</i>
Prostate Screening	■ Once a year test to detect cancer	3 of 8 plans cover
Cervical Cancer Screening	■ PAP test, and annual Ob/Gyn check ups	7 of 8 plans cover

¹Findings as a result of surveying CDHP designers. All plans surveyed offered coverage.
Source: 2006 HEDIS Measurements



Conflict 1: Definition of “Preventive Care”

Common P4P Measures	Description	Availability of First Dollar CDHP Coverage
Controlling High Blood Pressure	<ul style="list-style-type: none"> ■ Monitoring of lifestyle and adherence to prescription medications for supplemental benefits 	1 of 8 plans covered
Persistence of Beta-Blocker Treatment Post MI	<ul style="list-style-type: none"> ■ Beta-blocker recommended for all patients with prior heart attack, excluding those with contraindications 	1 of 8 plans covered
Cholesterol Mgmt for Patients w/ Cardio. Conditions	<ul style="list-style-type: none"> ■ Patients with established coronary heart disease who have a baseline LDL > 130 mg/dl should be on a cholesterol lowering drug 	1 of 8 plans covered
Use of Appropriate Medications for Asthmatics	<ul style="list-style-type: none"> ■ All asthmatics should be monitored for compliance with medications, such as bronchodilators and anti-inflammatories 	1 of 8 plans covered

¹Findings as a result of surveying CDHP designers. With the exception of Aetna, all plans surveyed did not cover any drugs and/ or extra tests associated with monitoring or evaluation of chronic conditions.
 Source: 2006 HEDIS Measurements, American College of Cardiology, AHA and Physicians Consortium for PI Chronic Stable Coronary Artery Disease



Conflict 2: Under-Utilization of Recommended Services and Drugs

Conflict	Discussion	Scenario
<p>Potential Under-Utilization of Medical Services as a Result of Greater Cost Shifting</p>	<ul style="list-style-type: none"> ■ Physicians in P4P programs want to comply with treatment protocols/ guidelines measured by payers ■ Some P4P measures may encourage more office visits for monitoring of chronic conditions (e.g., HbA1c levels 6 times a years vs. 3 times a year) ■ Other P4P measures encourage use of prescription drugs for monitoring of chronic conditions, which are not offered under first-dollar coverage ■ CDHP consumers might be unable, or unwilling to pay for extra office visits or tests associated with compliance of P4P practices or evidenced-based medicine ■ Additionally, as more chronically ill patients enroll in a CDHP plan, conflict is likely to arise ■ Physicians will increasingly need to justify treatment recommendations and value of extra services ordered 	<p><i>“With Bridges to Excellence, I may need to see a certain patient six times a year instead of three times a year so I can make sure his HbA1c is controlled. Patients may not want to come to the office and pay extra for those visits.”</i></p> <p style="text-align: right;">– Physician</p> <p><i>“If you can get through 1 year without using money, you are set.”</i></p> <p style="text-align: right;">– Consumer</p>



Conflict 2: Under-Utilization of Services

Service	1-Year Change in Utilization	
	CDHPs	Comparison Plans
Hospital Admissions	-5.2%	11.7%
Primary Care Visits	-10.9%	3.5%
ER Visits	-2.6%	4.2%
Hospital days vs. Market Average	-4.0%	-2.0%
Office Visits vs. Market Average	-1.0%	3.0%

Source: Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality, Health Affairs, October 2006



Conflict 3: Over-Utilization of Services

Conflict	Discussion	Scenario
<p>Over-Utilization of Clinically Unnecessary Services</p>	<ul style="list-style-type: none"> ■ Interviews suggest that physicians may “manage to metrics” rather than overall quality, since they don’t want to be perceived as under-performing ■ The emergence of tiered network products creates additional incentives to “manage to metrics” since low tiering status could impact both financial rewards and patient volume for physicians ■ Such measurements become more controversial in a CDHP world, in which patients have to pay for tests out of pocket 	<p><i>“We are required to do proteinuria levels to screen for diabetes. Once the patient tests positive [and we prescribe medication for the patient], we no longer need to do this test. However, we are still measured on the frequency of patients that have the test done annually, and we go ahead and prescribe the test to all patients – even though it is not clinically necessary for those already having a positive result.”</i></p> <p style="text-align: right;"><i>– Physician</i></p>



Conflict 4: Consumer Use of Clinical Data

Conflict	Discussion	Scenario
<p>Data Transparency and Consumer Use of Available Data</p>	<ul style="list-style-type: none"> ■ Only recently have physicians become accustomed to performance measurement, with many physicians still rejecting current methodologies of measuring performance ■ Health plans are driven by employers' desire to provide transparency to demonstrate value. Evolution of CDHP products requires certain level of availability and access to data to inform consumer choice ■ Currently, the ability of patients to access and use data is limited. Over time, information uptake will increase ■ Near term focus of plans on tiering physicians as means of communicating value ■ Conflict may exist when consumers attempt to challenge physicians' thinking and/or ask questions about physicians' performance reports 	<p><i>"I went to 4 years of college, 4 years of medical school, 3 years of residency and I have now been in practice for 24 years. P4P is an intrusion on what I do."</i></p> <p style="text-align: right;">– Physician</p> <p><i>"When it comes to how I'm doing taking care of patients, data collection is very inaccurate...I've experienced this with multiple plans, so it's not just one plan, but is system wide."</i></p> <p style="text-align: right;">– Physician</p>



Conflict 5: Physician Frustration With Non-Compliant Patients

Conflict	Discussion	Reactions
<p>Additional Frustration Over Non-Compliant Patients</p>	<ul style="list-style-type: none"> ■ While emphasis on compliance could be beneficial, it could generate additional conflict between the provider and non-compliant patients ■ Taken to extreme, physicians may limit practice to those patients that are more compliant with treatment regimen and protocols ■ This conflict is exacerbated in lower-income populations, which are often less compliant with treatment protocols and have greater health care needs 	<p><i>“Some doctor’s can’t get their patients to change behaviors at all- much less when there is added cost responsibilities on the part of patients. This tension will only increase, to some extent.”</i></p> <p style="text-align: right;"><i>– Physician</i></p>

Cost-Shifting to Patients May Further Exacerbate Non-Compliance in Certain Populations Who Aren’t Thinking Long-term



Conflict 6: Lack of Reliable Info on Quality/Cost Tradeoff

Finally, if the Overall Data Infrastructure and Information Management Tools Don't Keep Pace With CDHP and P4P Design, There is a Potential for Real Conflict as Consumers Attempt to Make Choices Based of Inadequate Quality and Cost Measures

Conflict	Discussion	Scenario
<p>Lack of Reliable Information on True Drivers of Quality and Trade Offs Between Quality/Cost</p>	<ul style="list-style-type: none"> ■ In a CDHP world, consumers increasingly responsible for making decisions as to the cost/ benefit trade offs associated with varying treatment protocols ■ However, there is industry-wide consensus that current measures to assess quality are in early stages and don't fully capture true picture of quality outcome and/or costs ■ Making data available to consumers and using it to inform patient behaviors creates illusion of scientific validity of quality/cost trade offs ■ Conflicts exists because data measurement tools are still in nascent stages, which may cause "newly engaged" consumers to make poor choices 	<p><i>“Tensions exist because cost consciousness of consumers is based on ‘phantom realities.’ We need to try to get to a point where the information out there lines up, and where the cost numbers available to consumers are the ‘true costs’ that reflect the total cost of care (including quality and utilization).”</i></p> <p style="text-align: right;"><i>– CDHP Designer</i></p>



Convergences

While There is Potential for Conflict Between CDHP and P4P, There is Also the Potential for the Two Trends to Converge in Meaningful and Synergistic Ways

Greater Alignment of Incentives

- Both trends will increasingly create and maintain incentives to achieve high quality, cost effective, and optimal care
- Advanced designs in CDHP will encourage consumers to utilize appropriate medical services (i.e., paying for consumer performance)
- Emerging P4P designs will incorporate cost effectiveness, efficiency, and value in medical decision-making

Development of Tiered Network Products

- If quality and costs can be adequately measured, tiered network products will assist CDHP enrollees in selecting “high performance” physicians and will likely further value-based purchasing agenda by driving both volume and extra reimbursement to these physicians

Fostering of HIT and Greater Data Capabilities

- Both trends will improve data analytic capabilities and measurement
- Conversely, both products will also be enhanced significantly by more robust data tools and measures
- Both trends will be facilitated and supported with greater adoption of health IT, interoperability, and transparency
- Conversely, the expansion of both trends will stimulate new market demand for technologies that can clarify cost/quality tradeoffs, identify high performance networks and physicians, and ease claims reconciliation



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