EMPOWERING PURCHASERS: ADVANCING TRANSPARENCY, INFORMATION, AND INCENTIVES

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Executive Director
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Who We Are

Catalyst for Payment Reform (CPR) is an independent, non-profit corporation working on behalf of large employers and public health care purchasers to catalyze improvements in how we pay for health services and to promote higher-value care in the U.S.

- 3M
- Aircraft Gear Corp.
- Aon Hewitt
- Arizona Health Care Cost Containment System (Medicaid)
- AT&T
- Bloomin’ Brands
- The Boeing Company
- CalPERS
- Capital One
- Carslon
- Comcast
- Dow Chemical Company
- eBay, Inc.
- Equity Healthcare
- GE
- Group Insurance Commission, Commonwealth of MA
- The Home Depot
- Ingersoll Rand
- IBM
- Marriott International, Inc.
- Ohio Dept. of Jobs and Family Services (Medicaid)
- Ohio PERS
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Safeway, Inc.
- South Carolina Health & Human Services (Medicaid)
- TennCare (Medicaid)
- Verizon Communications, Inc.
- Wal-Mart Stores, Inc.
- The Walt Disney Company
- Wells Fargo & Company
What We Focus On

Shared Agenda

Payment designed to cut waste or reflect/support performance

• Value-oriented payment that creates incentives to improve quality and contain costs
• 20% by 2020 as measured by National and Regional Scorecards

Special Initiatives

• Price transparency
• Reference and value pricing
• Maternity care payment reform

Environment

• Provider market power
• Private-public alignment
• Alternative routes to value
• Critical mass and a consistent ask
What We Do: CPR’s Two-Pronged Strategy

Market-Based Action

- Aligned purchaser agenda – short-term wins, longer-term bold approaches
- Clear signals to plans – RFIs, contracts, user group discussions and metrics, transparency tool specs
- Toolkit for local action – health plan user group toolkit, Market Assessment Tool, regional scorecards, action briefs, joint pilots, etc.

Shine Light on Urgency to Spur Reform

- Accountability: National Scorecard and Compendium on Payment Reform
- Raise visibility of payment variation
- Price Transparency State Report Card & statement
- Highlight provider market power issues & potential solutions
Market-Based Reforms with Wind in their Sails Across the Nation

Provider Consolidation – vertical and horizontal

Payment Reform “Arms Race”
- 20% of payments tied to value by 2020

Employers Shaking Up the Market
- high-performance networks, direct contracting, medical tourism

Delivery Reform – ACOs, PCMH, high-intensity primary care, group visits

New Markets for Insurance
- Private exchanges, state reforms, state exchanges

Engaging Consumers with Information:
- open notes, shared decision making, true informed consent, comparative effectiveness

Engaging Consumers with Incentives:
- VBID, reference pricing, tiered networks

ACA

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ACA
What are Purchasers Trying Today?

Consumerism, Benefit design, and Decision Support Tools:

• Consumer Directed Health Plans/Account-Based Plans
• Cost Sharing and Centers of Excellence
• Evidence-Based Plan Designs & Value-Based Insurance Designs
• Employee Cost Sharing
• Reference Pricing
• Reward/Penalize Health Improvement Activities
• Aggressive Management of Pharmacy Benefits
• Transparency
• Shared Decision Making
• Participation in ACOs and PCMHs
From Reference to Value Pricing

Reference Pricing establishes a standard price for a drug, procedure, service or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount.

Value Pricing is when quality is also taken into consideration in addition to the standard price.

- Signal to providers that payment variation isn’t tolerable
- Engages Consumers

Growing in Popularity Among Purchasers
Nationally: 5% in 2013; 15% in 2014*

*NBGH/Towers Watson

Over $3 million in savings in first year of hip/knee replacement program; some high-priced providers renegotiated

Application to colonoscopies and other services has held per capita health care costs nearly flat

Spectrum of Reference Pricing
What are Purchasers Trying Today?

Network design, alternative sources of care:

• Limited, narrow, tiered or customized high-performance networks (e.g. Group Insurance Commission)
• Onsite, Near Site, or Mobile Clinics
• Telehealth
• Direct contracting
Price is the leading driver of health care cost growth today

Consolidation pushes payments 3% higher nationwide
What are Purchasers Trying Today?

Payment Reform

- PCMH
- ACOs
- Bundled payment
- Non-payment for care that doesn’t follow guidelines
- Practice patterns straying from the evidence
  - Pre-term elective births
  - Unnecessary intervention
  - Worse outcomes and higher costs
- The way we pay today creates incentives for unnecessary intervention
  - Need to insert right incentives
  - Blended, bundled payment
  - Non-payment for early elective deliveries

US is moving farther away from goals

www.catalyzepaymentreform.org

October 2, 2013
What are Purchasers Trying Today?

Efforts to improve employee health:

• High-Cost Case Management Programs
• Financial Incentives for Health Improvement
• Require Employee Engagement to Receive Health Benefits
• **Leg 1:** Discounts in return for volume
• **Leg 2:** Unfettered access, insulation from costs
• **Leg 3:** Awareness of variation and poor value, engaging consumers, transparency, creating incentives, seeking alternative sources of care

• **Leg 4:** Shaping provider and consumer behavior with a stronger market, identification of best overall value, payment varying with quality and cost, willingness to select select providers, public and private exchanges...

**Road Map**

**Where is the health care system going?**
**What’s the next leg of the journey?**
**Who takes the wheel?**

We are here

**Lookout for new opportunities**
Three Pillars

- Information
- Transparency
- Incentives
Huge quality variation

- Quality Measures would be different if set by purchasers: measures on areas of performance where improvement could lead to the greatest reduction in harm, with the greatest variation on quality and price, areas of greatest cost
- Instead we have measures that are easy to collect and show little variation across providers and meaningless to consumers
- But we know enough to know there are massive failures
Huge payment variation (amounts)

Table 6: Observed Prices for Selected High-Volume Maternity DRGs by Severity of Illness, 2009

<table>
<thead>
<tr>
<th>APR-DRG and severity</th>
<th>Minimum price</th>
<th>Median price</th>
<th>Average price</th>
<th>Maximum price</th>
<th>Difference between maximum and minimum price</th>
<th>Ratio of maximum to minimum price</th>
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<tbody>
<tr>
<td>Cesarean delivery ($40)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Severity 1</td>
<td>$3,244</td>
<td>$7,598</td>
<td>$7,859</td>
<td>$15,915</td>
<td>$12,671</td>
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<tr>
<td>Severity 2</td>
<td>$2,828</td>
<td>$8,718</td>
<td>$9,338</td>
<td>$20,424</td>
<td>$17,596</td>
<td>7.2</td>
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<tr>
<td>Severity 3</td>
<td>$3,621</td>
<td>$11,389</td>
<td>$13,266</td>
<td>$26,018</td>
<td>$22,397</td>
<td>7.2</td>
</tr>
<tr>
<td>Severity 4</td>
<td>$9,600</td>
<td>$17,134</td>
<td>$19,156</td>
<td>$30,660</td>
<td>$21,059</td>
<td>3.2</td>
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<tr>
<td>Vaginal delivery ($60)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity 1</td>
<td>$1,810</td>
<td>$4,990</td>
<td>$5,225</td>
<td>$11,066</td>
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<td>Severity 2</td>
<td>$2,182</td>
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<td>$5,884</td>
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<td>$7,656</td>
<td>$20,446</td>
<td>$17,634</td>
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</table>

Source: Mathematica Policy Research analysis of private insured and self-insured fee-for-service claims for Massachusetts residents.
Note: Payments include patient cost-sharing in fee-for-service coverage. Payments made under managed care contracts are not included.

Huge payment variation (methods)

• See CPR’s Scorecards...
2010 estimate was 1-3% of payments were tied to performance

2013 Scorecard found 10.9% of commercial in-network payments are value-oriented

57% of the value-oriented payment is considered “at-risk”

11% of payment to hospitals is value-oriented

6% of outpatient specialist and PCP payment is value-oriented

Scorecard results possibly biased upward
Slow Progress On Efforts To Pay Docs, Hospitals For 'Value,' Not Volume

Payment Reform: A Promising Beginning, But Less Talk And More Action Is Needed

The Washington Post

How Fortune 500 companies plan to cut health costs: Act like Medicare

ModernHealthcare.com

Value-based insurance plans gain momentum
- 41.8% of commercial in-network payments are value-oriented.
- 97% of the value-oriented payment is considered “at-risk”.
- 32.5% of California’s payment is capitation with quality.
- 36% of commercial health plan members are “attributed”.
- CA’s health care spending per capita ($6,238) is 9th lowest in the nation.
- But, huge variation across payers, examples of poor quality: maternal mortality, cesarean deliveries, flu vaccines and diabetes screenings.
- Where’s the value in value-oriented?
Three Pillars

Information

Transparency

Incentives
Transparency

Quality Transparency
• Head start, especially for hospitals
• Voluntary efforts will fall short – Leapfrog Group

Price Transparency
• Private and public efforts (34 states with laws)
• Medicare has some tools
• Private sector competing for appetite

Best Overall Value
• Combining quality with price information
• Consumers will make the right choices
Understanding the Cost & Value of Care

Fall 2013
Evaluation of Consumer Transparency Tools
Report on State of the Art of Transparency Tools
Updated Specifications for Transparency Tools
Health Care Prices Remain A Mystery In Most States

Many states don’t require disclosure of prices for medical procedures

The Washington Post

THE WALL STREET JOURNAL.

Most of U.S. flunks health price transparency test: study
One of only two states in the nation to receive and A grade (in addition to New Hampshire) – **but on a scale!**

- Myhealthcareoptions – *only* most common inpatient and outpatient services and procedures and no user customization
- Will this progress or stop short here?
### Detailed estimates for Vaginal Birth and New Baby (inpatient)

**Procedure:** [Vaginal Birth and New Baby (Inpatient)]

**Insurance Plan:** CIGNA, Preferred Provider Organization (PPO)

**Within:** 50 miles of 03301

**Deductible and Coinsurance Amount:** $1,500.00 / 20%

<table>
<thead>
<tr>
<th>Lead Provider Name</th>
<th>Estimate of What you Will Pay</th>
<th>Estimate of What Insurance Will Pay</th>
<th>Estimate of Combined Payments</th>
<th>Precision of the Cost Estimate</th>
<th>Typical Patient Complexity</th>
<th>Contact Info</th>
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<tbody>
<tr>
<td>ALICE PECK DAY MEMORIAL HOSPITAL</td>
<td>$2342</td>
<td>$3372</td>
<td>$5714</td>
<td>LOW</td>
<td>MEDIUM</td>
<td>ALICE PECK DAY MEMORIAL HOSPITAL 603.448.3121</td>
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<td>$2447</td>
<td>$3792</td>
<td>$6239</td>
<td>MEDIUM</td>
<td>VERY HIGH</td>
<td>SPEARE MEMORIAL HOSPITAL 603.536.1120</td>
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<td>MONADNOCK COMMUNITY HOSPITAL</td>
<td>$2683</td>
<td>$4732</td>
<td>$7415</td>
<td>LOW</td>
<td>LOW</td>
<td>MONADNOCK COMMUNITY HOSPITAL 603.924.7191</td>
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<td>PARKLAND MEDICAL CENTER</td>
<td>$2995</td>
<td>$5980</td>
<td>$8975</td>
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<td>PARKLAND MEDICAL CENTER 603.432.1500</td>
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<td>ST JOSEPH HOSPITAL</td>
<td>$3054</td>
<td>$6219</td>
<td>$9273</td>
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<td>HIGH</td>
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<td>ELLIOT HOSPITAL</td>
<td>$3062</td>
<td>$6249</td>
<td>$9311</td>
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<td>HIGH</td>
<td>ELLIOT HOSPITAL 603.669.5300</td>
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<td>$6487</td>
<td>$9608</td>
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<td>HIGH</td>
<td>CATHOLIC MEDICAL CENTER 800.437.9656</td>
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<td>CHESHIRE MEDICAL CENTER</td>
<td>$3218</td>
<td>$6876</td>
<td>$10094</td>
<td>HIGH</td>
<td>MEDIUM</td>
<td>CHESHIRE MEDICAL CENTER 603.254.5100</td>
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</table>
Three Pillars

- Information
- Transparency
- Incentives
There is momentum behind transforming payment to providers and incentives for consumers. . .

- Health Reform Included Several “Game Changers” - Some Will Take Time And They Will Be Disruptive

- Focus On Specific Models – But Is There Some ‘Irrational Exuberance’ At Work?

- We Still Know Very Little About What Works

- Our Current System Will Be Around For A While - And We Shouldn’t Ignore It
Provider Incentives

• Migration from carrots to carrots & sticks

• Any carrots have to be sustainable

• Savings don’t reach the end users
  • Many approaches being modeled, but translation of savings to purchasers and affordability hasn’t happened – at the end of the day, it’s about the price

• Competition can be its own incentive
Consumer Incentives

- Information must be paired with incentives

- Examples: Reference pricing, select provider networks, centers of excellence, value-based insurance design

- With the right information, consumers will choose a high-quality provider (defined as lowest price with best quality) 80 to 90 percent of the time
All Eyes on Massachusetts
Questions to Ponder

• How will the patient experience change over the next 5-7 years as a result of these trends?"

• How will provider behavior change as they are increasingly at financial risk for their performance on cost and quality?

• What will be the role of the health insurer?

• Will employers use their potential leverage to drive reforms to make health care higher-quality and more affordable?

What could shift the current direction of reforms?
Contact

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