

# Cost Containment: Strategies from California, Implications for Reform

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# Pacific Business Group on Health

- The Pacific Business Group on Health helps employers improve the quality of health care and limit health care cost increases for their employees.
- PBGH serves as a voice for purchasers, leveraging the strength of its 60 member companies, who provide health care coverage to 10 million Americans and their dependents.

# PBGH Members

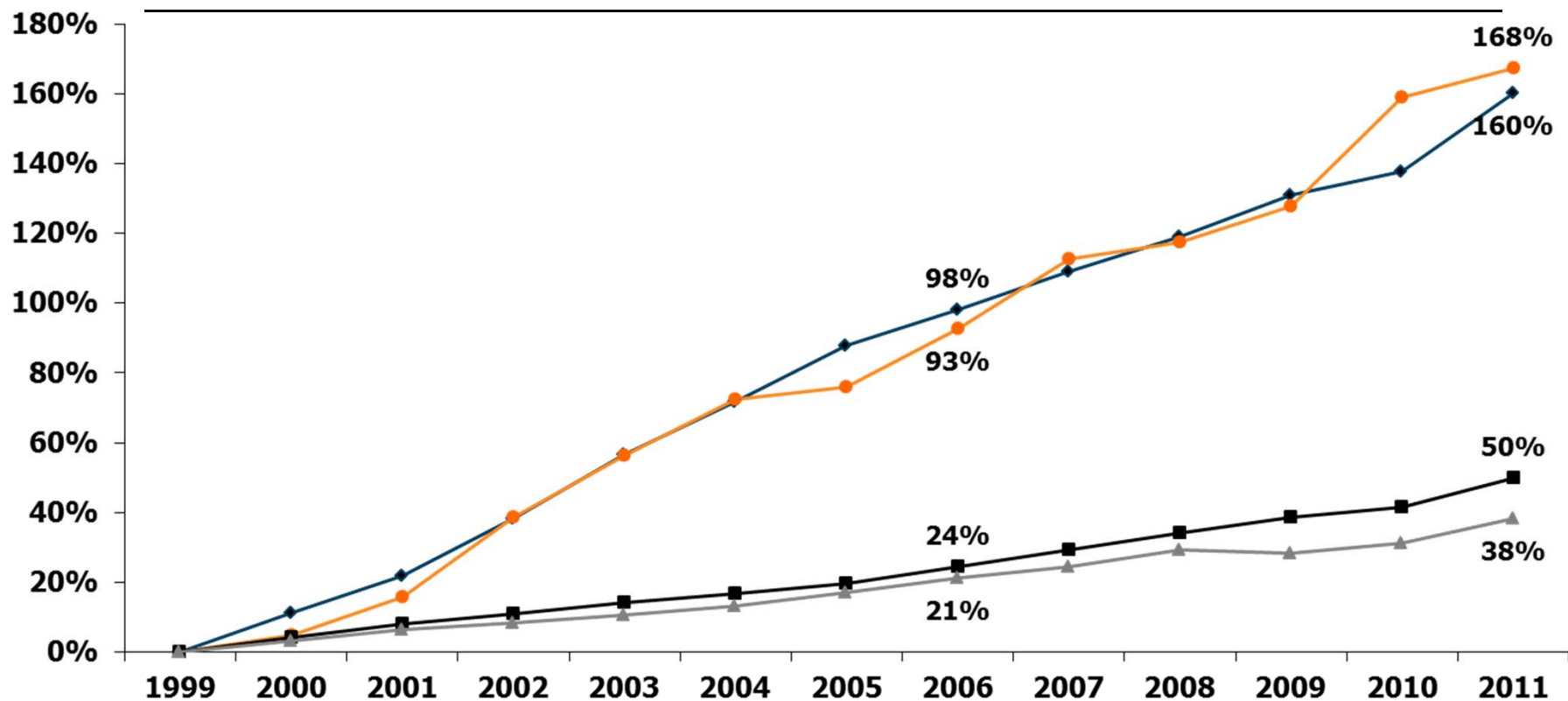


# Rising health care costs

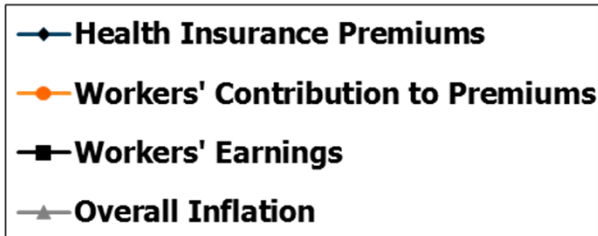
- Eat away at wage growth
- Threaten profitability
- Make employers think about getting out of the job of managing health benefits



## Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2011



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2011; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2011 (April to April).

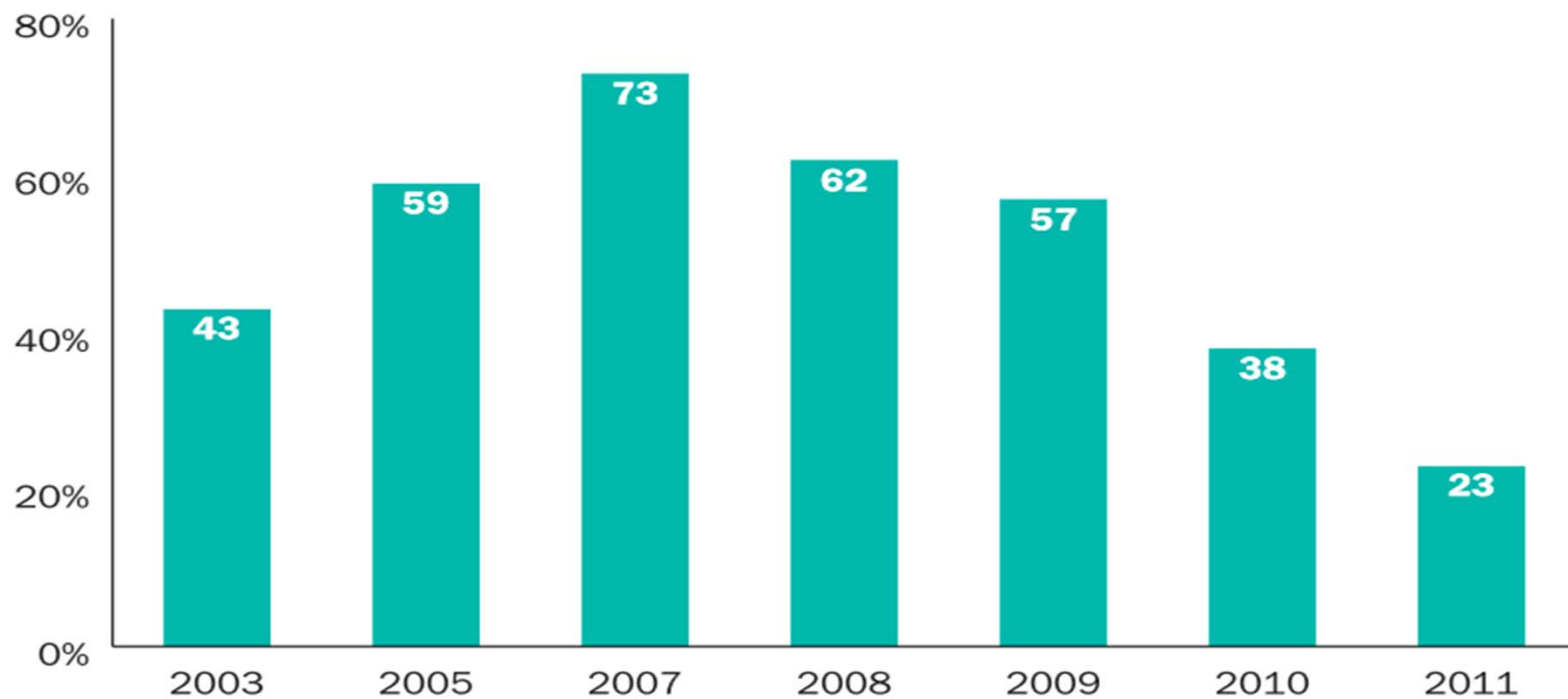


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# Employers are Rethinking their Strategies

**Figure 13. Employers' confidence that health care benefits will be offered at their organization a decade from now continues to erode**



Note: High confidence represents responses of "very confident."

**Source:** 2012 17th Annual Towers Watson/National Business Group on Health. *Employer Survey on Purchasing Value in Health Care*

# Employer concerns

- Costs continue to rise
- Quality of care is variable, with little transparency
- Cost of care is unrelated to quality
- Current tools – CDHP, P4P, quality measurement – having little impact
- Hope for health plans to fix the problem has faded
- Hope that managed care will lead to cost reduction has faded
- Most delivery systems and health plans show little motivation to seek efficiencies, improve quality
- Health reform is unlikely to slow cost increases
- Consolidation of health plans and provider systems is likely to lead to increased prices

➤ *Time for fundamental re-evaluation*



# Old Strategies to Reduce Employer Costs

- Reduce benefits
- Reduce eligibility for benefits (eliminate benefits for retirees, increase part-timers, increase use of contractors)
- Increase employee cost sharing (contributions to premium, higher deductibles, CDHP)
- Push health plans to negotiate discounts from providers

*These may reduce costs for employers in the short-run, but they don't reduce the costs of health care.*

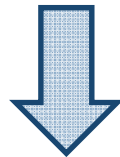


# Next Generation Strategies

Engage Consumers



Pay for Value



Redesign Care Delivery

→ *Lower Health Care Costs*

1. *Engage consumers:* Modify benefits and incentives to motivate consumer behavior changes

# Engaging Consumers: the CalPERS approach

- Value Based Purchasing Design, in partnership with Anthem Blue Cross.
- Set a payment threshold for certain elective procedures.
- Patient can choose any provider, but pays the difference if the price is higher than threshold.



# Applying the concept to hip/knee replacements

- Price varied from \$15,000 to \$110,000 (commercial PPO population)
- No relationship between price and quality of care
- Payment threshold set at \$30,000

## Results:

- Average amount paid per procedure: *26.5% reduction*
- Volume at low-cost facilities: *6.8% increase*

And, some facilities are now negotiating reduced costs.

*This is healthy competition in action!*

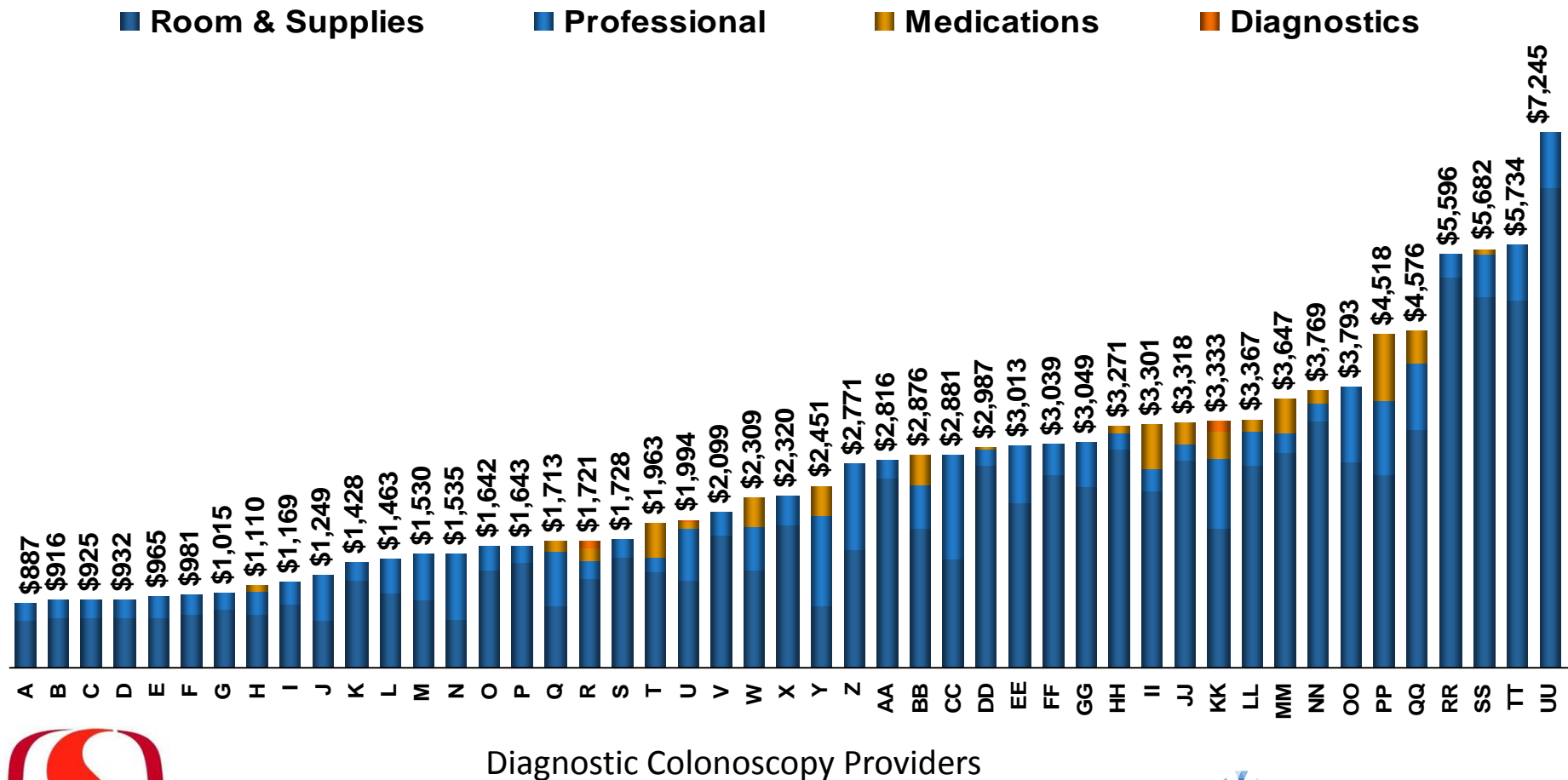
# Engaging Consumers: the Safeway approach

Wellness meets  
consumer directed health care



# Reference pricing for Colonoscopies

## Cost Per Procedure – Greater SF Bay Area MSA



*2. Pay for Value: Adopt  
provider payment methods  
that align incentives and  
reinforce accountability*



# Paying for Value: CalPERS ACO

- 41,000 CalPERS members in Blue Shield HMO plan
- Partnership with Blue Shield, Catholic Healthcare West (Dignity Health) and Hill Physicians
- Reduced hospital re-admissions by **17 percent**, slashed **half a day** from the average hospital length of stay
- Savings estimated at **\$15 million** annually



*3. Redesign Care:* better systems  
to deliver quality care at the  
right cost

# Redesigning Care: Boeing IOCP

Intensive Outpatient Care Program:  
Personalized care for the chronically ill



**HEALTH  
AFFAIRS**  
*The Policy Journal  
of the Health Sphere*



*“Patients incur **15–20 percent less** total health care spending per year than patients treated by regional peers, without evidence of reduced quality...”*

# Redesigning Care: Boeing IOCP






Key elements:

- The program focused on **high risk patients**, i.e., the 5-20% who incur the highest costs.
- Each site created a new ambulatory intensivist practice, staffed by a physician, a **nurse “health coach”**, and other support.
- **Copays for the initial intake visit were waived**; there were no other benefit changes.
- Sites were paid a **case rate per member per month** (pmpm) to cover non-traditional services; otherwise, the sites continued to be paid based on traditional fee-for-service contracts.
- The sites **received a portion of the savings** in total medical expenses.



# Boeing IOCP Results

IOCP Boeing Pilot results as published on Health Affairs blog 2009.10.20:

Measure compared to baseline	Result
Health care costs of pilot participants versus control group	- 20.0% 
Hospital admissions	- 28% 
Improvement in mental functioning of pilot participants	+ 16.1% 
Participants feeling that care was "received as soon as needed"	+ 17.6% 
Average number of patient-reported workdays missed, 6 months	- 56.5% 

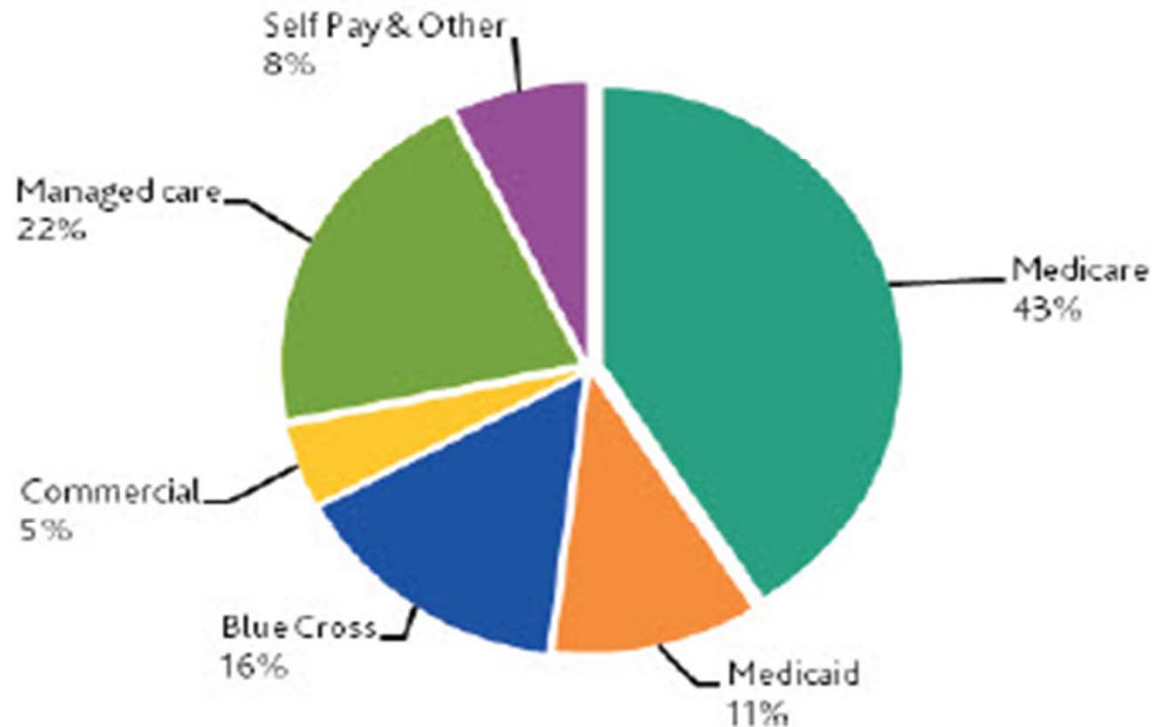
# Impact of Private Employer Strategies

- Despite success with pilots, we haven't bent the cost curve significantly.
- Why? **No one employer represents a significant share of a hospital's revenue.**
- Result: innovations are slow to spread → cost trends continue upward

# Who can move the market?

FIGURE 3

## Medicare Typically Represents Largest Payer for Hospitals\*



\*Based on FY 2010 medians; numbers do not necessarily sum to 100% because each payer is a separate median calculation.

Source: Moody's



# Policy Principles for Cost Containment

- Health reform must **reduce medical costs**, not just reduce government expenditures.
- It should **not just shift costs to employers** (e.g., via raising the eligibility age) **or to beneficiaries** (e.g., via raising deductibles)
- Any reform must address the **problem of traditional FFS**, which provides incentives to provide more volume of services without regard to appropriateness or quality.
- Reform should also provide **incentives to consumers to shop wisely** for the providers that offer the best value (quality/cost)

# Policy Agenda to Drive Value: Short-term

Move ahead with current programs and pilots:

- Payment reform: Hospital Payment reforms, Physician VB Modifier, bundled payment pilot
- Delivery system reform: ACOs, PCMHs
- Other key value-promoting policies: Exchanges

These are headed in the right direction, but they lack the scale and speed to get the cost reduction we need.

# Policy Agenda to Drive Value: Long-term

Many possibilities from various studies and deficit reduction plans.

Our recommended top 3 – with the most leverage:

1. *Payment reform*: rapid implementation of **bundled payments**, moving to global payments
2. *Benefit redesign*: use of **reference pricing, tiered networks** and similar incentives to encourage healthy competition among providers
3. *Delivery system reform*: rapid development of ACOs, PCMHs and similar **delivery system innovations**.

# Payment reform

## *Rapid implementation of **bundled payments***

- High cost procedure (e.g., total knee replacement, CABG)
  - Expand ACE demonstration to other hospitals
- High cost, stable chronic illness (e.g., diabetes, cancer, coronary artery disease)
- Other services, as quickly as feasible

### Need:

- Commitment to this approach for provider payment
- Standardized definitions of bundles/episodes of care
- Flexible approach for different delivery systems

# Benefit redesign

*Expanded use of **reference pricing** to encourage healthy competition among providers*

- Routine elective procedures and other high cost procedures (e.g., total knee replacement)
- Other procedures or episodes to be developed

Need:

- Commitment to this approach for benefit design
- Careful application to ensure consistent quality

# Benefit redesign

*Use of **tiered networks** to encourage healthy competition among providers.* For example:

- Identify “gold star” providers that provide high quality, efficient and appropriate care.
- Provide incentives (e.g., lower Part B premiums or deductibles) for beneficiaries who use these providers.

Need:

- Commitment to this approach for benefit design
- Good performance data on providers
- Careful design of incentives

# Delivery system reform

*Rapid development of ACOs, PCMHs and similar delivery system innovations.*

Need:

- Commitment to encouragement of care coordination and delivery system integration
- Flexible approach for different delivery systems



# Medicare Barriers to be Overcome

- FFS payment → incentive for increased volume → unnecessary services
- Provider silos (Part A, Part B, etc.) → inadequate incentives for physicians to manage total costs → lack of care coordination

## Need:

- Commitment and clear path to move from volume-based to value based payment
- Flexibility to pay groups/systems of providers

# Moving Ahead with Next Generation Strategies

1. Engage Consumers
2. Pay for Value
3. Redesign Care Delivery

These aren't new ideas, but we need to:

- **E x p a n d**
- **Strengthen**
- *Accelerate*
- **Align**

# Alignment and Scale are Essential

Public and private sector purchasing strategies must be aligned – to give a clear and consistent signal to providers.

## Building sufficient scale

1. Private purchaser innovation
  2. Medicare adoption
  3. Widespread private purchaser adoption
- **Cost containment**

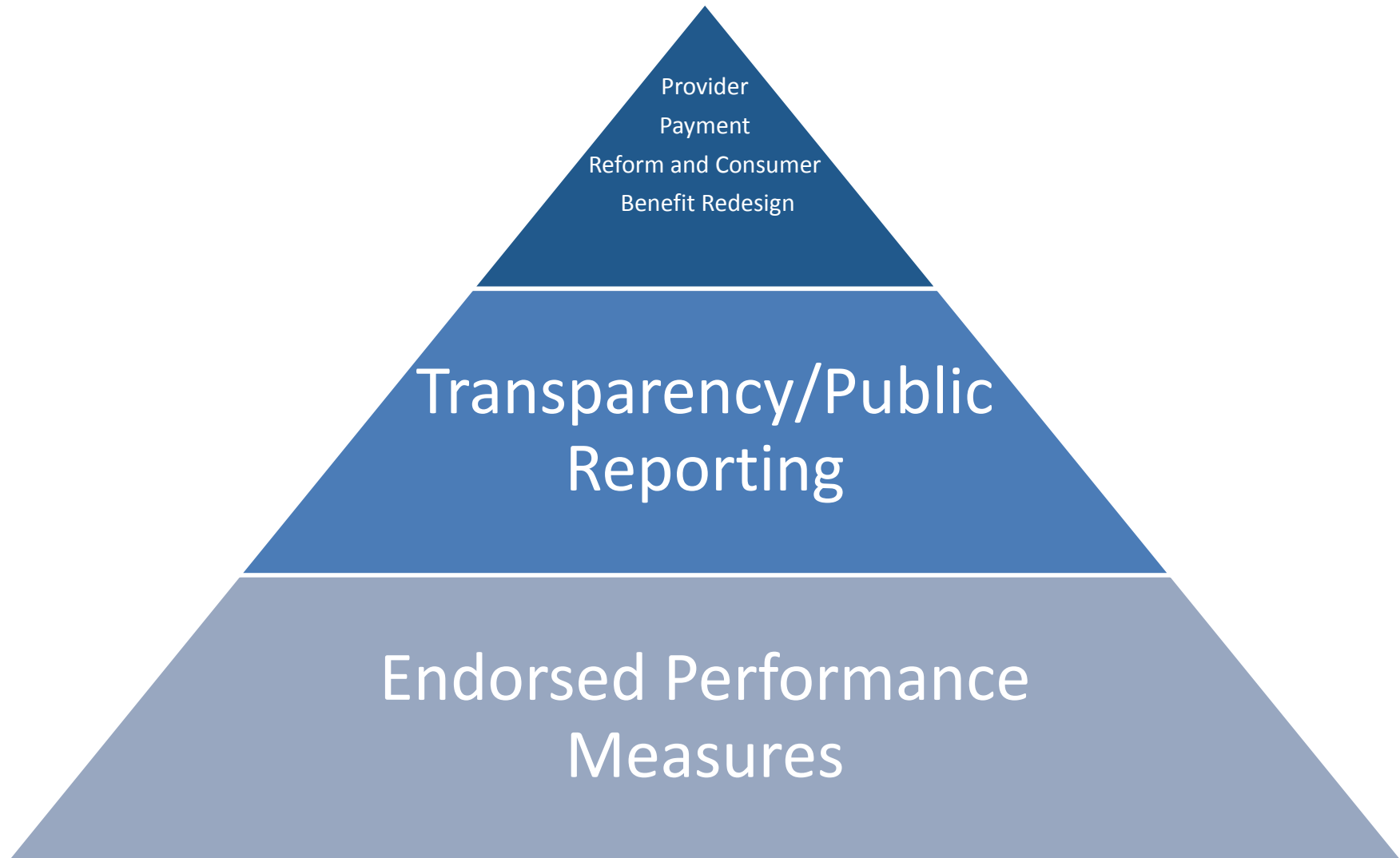
# Next Generation Strategies Need a Strong Foundation

- Provider and consumer incentives offer the most leverage, but we also need a **strong information infrastructure**:
  - better measures
  - public reporting
  - meaningful use of HIT
- Essential to **continue and expand funding** for consensus development of:
  - Quality improvement strategies and selection of priority performance measures
  - Development, review and endorsement of new measures to fill the gaps, especially clinical outcomes, patient experience, care coordination and cost/resource use.

“Fantasy baseball managers have far more data to evaluate players for their teams than patients and referring doctors have in matters affecting life, death and disability.”

George Shultz, Arnold Milstein & Robert Krughoff  
September 2011

# The Foundation for Market Based Reform



No single initiative will be enough – they all need to work together to get full impact





# Summary

- We have an **urgent problem**: health reform isn't done until we deal with the cost problem
- **Current pilots** in the private and public sectors are promising, but they **aren't sufficient**
- Use what has worked in the pilots, but **build scale and accelerate adoption**
- We need **bold solutions**, not incremental change
- **Private sector** employers will **work with public purchasers** to do this.

# For more information:

- Learn more about the Pacific Business Group on Health and our effort to improve the quality of health care while moderating costs at [www.pbgh.org](http://www.pbgh.org)
- Learn more about our work to bring employers, consumers and labor organizations together to improve access to publicly reported health care performance information at [www.healthcaredisclosure.org](http://www.healthcaredisclosure.org)
- Learn more about our efforts to reform payment at [www.catalyzepaymentreform.org](http://www.catalyzepaymentreform.org)