COLORADO
BUSINESS GROUP ON
HEALTH

Date:	September 14, 2015
Name of the respondent:	Donna Marshall, Executive Director
Affiliation/Organization:	The Colorado Business Group on Health
Email and phone number:	donna.marshall@cbghealth.org/ 303.922-0939

1. **How We View the Fundamental Cost Drivers.** Setting aside the observation that 60% or more of the incidence of disease in the US is estimated to be driven by risk behaviors (e.g., overeating, alcohol misuse, smoking, etc.), we would observe that the same primary drivers of other markets – supply and demand – explain healthcare. In healthcare, however, supply and demand interact uniquely from other industries and drive costs in strikingly different ways dependent upon the type of care/service.
    a. ***Lack of Risk Identification to Enable Early Intervention.*** There is an estimated one-third of Colorado employees who are pre-diabetic while at least that percentage has undiagnosed hypertension and early signs of coronary artery disease. The lack of cost avoidance strategies – such as implementation of the National Diabetes Prevention Program and building cultures of health at worksites and in communities -- clearly contributes to the conversion of employees who are simply "at-risk" of chronic disease to employees with a chronic disease.
    b. ***Chronic Care.*** Analyses completed by the CBGH utilizing the Prometheus model for quantifying the compliance of provided health care services on a patient-by-patient basis with evidence-based protocol clearly reveals two major issues in how chronic conditions are (and are not) managed:
        i. *Potentially Avoidable Complications – A Supply Side Issue*. Potentially avoidable complication rates (e.g., the percent, by cost, of healthcare services for patients with chronic disease(s) that represent poor outcomes) range from 25% to as much as 60% by disease type and by provider.
        ii. *Underutilization of Needed Services – A Supply and Demand Side Issue*. The same analysis on a community of employers in Colorado Springs demonstrates that, across multiple employers, the vast majority of patients with a chronic disease (e.g., 70-80% by employer) typically receive only about 50% of the health care services that would have been warranted given their specific condition(s) and comorbidities. This underutilization appears to be the result of:
            1. Patient non-compliance and lack of seeking care (e.g., demand). We have observed that patients with chronic conditions who have not seen a physician in three years are 10-15 times more expensive than those who have. Additionally, it is well documented that, 12 months after prescribing medication for most diseases, compliance among chronic care patients averages only about 50%.
            2. Inadequate patient engagement and out-reach (e.g., supply). Primary care is the cornerstone of medical management, and yet,

systems for patient outreach, patient engagement, and accountability for outcomes are lacking.

c. ***Episodic Care – Price and Appropriateness.*** Whereas chronic care is typically under-valued/priced and under-utilized, the issues with episodic care are the exact opposite. From a routine urinalysis test to an open heart surgery, two primary issues drive excessive costs and waste with regard to episodic care: 1) excessive and unwarranted pricing variations for the same service in the same market and 2) the inappropriate delivery of oftentimes excessive or even unwarranted services.

   i. *Unwarranted Price Variation*s. As documented by Healthcare Bluebook and the others, prices for routine healthcare services such as blood tests or screening colonoscopies without biopsy can range from 250% to 1100% - with no demonstrable difference in quality. A normal delivery in the Denver market ranges, in 2015, from $4,471 to as much as $16,094 (according to Healthcare Bluebook) while the costs of a joint replacement can vary by over 300% according to the Colorado All Payer Claims Database. Two factors effectively accelerate the problems with episodic care.

      1. Business to Business Model. Rather than functioning as other retail markets as a "business to consumer" model where supplier success rests on consumer satisfaction with the trade-off between quality and cost, healthcare is built on a wholesale, business to business model whereby prices are set by two parties, the health plans and the providers. This results in opaque and ever increasing costs to employers and consumers.
      2. An Oligopolistic, Consolidated Market. The business to business model described above accelerates the creation of an oligopolistic market. Because it rewards being big (either as the insurer or as the provider) rather than being good, it increasingly incentivizes consolidation. While pursued in the name of pursuing "economies of scale" and efficiencies from "vertical integration," the literature shows no evidence that behemoth provider systems have either achieved or passed along savings. Additionally, since pricing is opaque to consumers, as one system raises prices and rates, so do the others. Studies by the Catalyst for Payment Reform and others have shown that both hospital-hospital and hospital-physician acquisitions have increased consumer prices. We have seen, and others have documented the unwarranted addition of "facility fee" costs to physician and other outpatient visits due to market consolidation.
      3. Lack of Price Transparency for Patients Seeking Urgent Care. Patients may feel that they need medical attention urgently. They may not have a primary care provider, or a provider with convenient access. Patients may seek care at an urgent care site, or retail clinic site, or may access an emergency department instead. Many patients seek care at an urgent center, or retail clinic with the knowledge that this is a better choice than an emergency department. However, because pricing is opaque, patients will not

know that a health plan may adjudicate a retail clinic visit with a copay that is higher than the actual posted cost of the visit or that the urgent care center is now a "mini-ED" and a huge facility fee will be tacked onto the cost of the visit.

ii. *Appropriateness*. As reported in the *New York Times* (July 26, 2013) and published in the August 2013 issue of the *Mayo Clinic Proceedings*, "scientists reviewed each issue of *The New England Journal of Medicine* from 2001 through 2010 and found 363 studies examining an established clinical practice. In 146 of them, the currently used drug or procedure was found to be either no better, or even worse, than the one previously used." In other words, "more than 40 percent of established practices studied were found to be ineffective or harmful, 38 percent beneficial, and the remaining 22 percent unknown." This problem is further illuminated by an initiative called "Choosing Wisely". In 2012, the American Board of Internal Medicine asked the specialty societies to make recommendations to reduce or eliminate unwarranted tests, practices and procedures. Over 400 unique items have been identified and are posted on a public website for patient and physician edification. Again, the unique interaction of supply and demand in healthcare combines to produce such inefficiency.

d. ***Escalation of Pharmaceutical Costs Including Prices for Generics, Brands, and Specialty Medications.***

2. **Barriers to Reducing Cost.** Because the drivers vary by type of care, the barriers similarly vary.

a. ***Risk Reduction/Employee Engagement***. Risk reduction is a long term enterprise, and represents the most significant hurdle to reducing cost – not because we haven't the tools or because we don't know what works, but because the underlying issue is employee engagement at two levels:

i. First, risk identification activities such as health risk appraisals or biometric screening can effectively quantify risks. Obtaining employee participation, however, requires both cultural, financial solutions and benefit design solutions.

ii. Second, even if an employer is successful in identifying employees who either have or are at risk of having a chronic condition/acute episode, engaging employees to change behaviors represents a significant challenge. This is particularly true when it comes to obesity – a national epidemic.

b. Chronic Care. The primary intermediate barrier to effective and efficient chronic care is under-utilization of high value services (typically preventive and primary care). In CBGH's experience, 80% of patients with a chronic disease receive only half the care that evidence-based protocols suggest they should receive. The root causes of such extensive underutilization stem from provider side (supply) and user

(demand) side issues.

i. Provider Side: On the provider side....

1. Physician practices and their medical directors lack clinically actionable feedback on adherence to evidence- based protocols. Although this is changing, historically health plans only provide feedback on costs and statistically, not clinically, based targets.
2. Physicians are not rewarded for superior outcomes (which is not the same as just reducing costs) unless there is a pay- for- performance or bundled payment approach.
3. Primary care providers typically have only a partial picture of what's going on with their patients and depend primarily upon specialists to voluntarily provide feedback on treatment regiments, services rendered, and prescriptions ordered.

ii. Demand Side. A lack of incentives for enrollees – particularly those with or at risk of having or who already have a chronic condition – to select and seek care from primary care physicians represents the main barrier to improving outcomes and reducing avoidable costs.

1. Unfortunately, few employees with chronic diseases or at risk of a chronic disease have financial incentives to seek primary care and to remain compliant with comprehensive health care plans.
2. Increasing, high deductible health plans (HDHPs), originally intended to ensure that employees have "some skin in the game," are actually exacerbating the problem by causing enrollees to postpone appropriate primary care to monitor a chronic health condition.
3. Many employees seek care from a specialist without a linkage to or communication with a primary care provider.

c. Episodic Care. Several factors represent barriers to a more cost-effective use of episodic or acute care services. These include:

i. Health care literacy. Few consumers understand healthcare well enough to be informed consumers while, at the same time, the majority of resources available to consumers seem to be written at levels well above the understanding of health care consumers.

ii. Lack of Transparency. Lack of information on quality and price that consumers can readily use has historically prevented consumers from making informed decisions. Slowly this barrier is being reduced by consumer-focused tools such as Castlight and Healthcare Bluebook.

iii. Payment Methodologies. Current fee for service methodologies encourage volume over value.

iv. Benefit Design. While we know that health services can be ranked in value and need from low to high, benefit designs in general cover all services as if they were of equal value. Value-Based Benefit Designs seek to stratify and reduce cost sharing for high value services.

d. Pharmaceuticals.

i. There is lack of adherence by patients, because of costs or side effects, or knowledge of the importance of the medication. Patients are not monitored to see if therapeutic outcomes are achieved, or whether dosages should be titrated or substitute medications prescribed. This means that a drug may have been cost effective, and the cost of the medication may have been offset by other medical savings, but this will not occur.

ii. Efficacy and cost effectiveness are rarely discussed with the patient by prescribing physicians. Physicians do not know the cost of many of the drugs they prescribe, and may not have high rates of generic prescribing.

iii. Drugs may be overprescribed, for example, opioids.

iv. Oncology and other medications may not be prescribed in accordance with national or international guidelines, ie a renowned body such as the National Institute for Health and Care Excellence (NICE)

3. **CBGH Programs That Address Costs.** CBGH sponsors and promotes a variety of programs design to address costs, primarily:

a. ***Episodes of Care for Improving Chronic Care***. (Healthcare Incentives Payment Pilot, or HIPP). In Colorado Springs we are piloting a program whereby employers are directly engaging providers in addressing many of the above barriers in a systematic model we term "Mutual Accountabilities." This model – negotiated between employers and providers over the past year – holds employers, primary care physicians, and employees accountable for specific responsibilities aimed to attain the Triple Aim goals. A measureable outcome will be reduction of potentially avoidable costs associated with these chronic conditions.

b. ***Bridges to Excellence (BTE)***. Since 2007 we have sponsored the BTE program which recognizes and rewards physicians whose clinical outcomes for the diabetic and cardiac patients they see meet or exceed national standards. Over $300,000 in awards have been paid by 8 participating health plans and employers on behalf of over 2,800 patients to Colorado physicians who have attained recognition.

c. ***Transparency*****.** Several CBGH programs support and promote transparency across several components of the health care industry. These include:

i. Leapfrog – measuring hospital performance on critical infrastructure elements related to patient safety.

ii. Healthcare Bluebook – profiling in-patient and out-patient providers on quality performance and prices.

iii. eValue8 – comparing the performance of health plans on a variety of measures to both each other and national standards.

d. ***Support for an employer initiative for a negotiated price for hip and knee replacement surgery.*** One CBGH member is piloting a program that will reduce costs of care for their members, and their plan beginning in 2015. Other employer members of the CBGH are intending to replicate this program as the beginning of payment reform using bundled prices for certain procedures.

e. ***Participation in Better Care. Better Costs. Better Colorado (BC3).*** This initiative is working along 3 initiatives this year: reduction of inappropriate ED utilization, assisting in the SIM grant, and transitions of care.

f. ***Support for the All Payer Claims Database (APCD) and the Center for Improving Value in Health Care (CIVHC).*** CBGH actively promotes, publicizes and uses the data from the APCD in employer and community forums in order to increase awareness and uptake of this valuable resource.

4. Supporting data that demonstrates a reduction in cost?

a. ***Episodes of Care for Improving Chronic Care***. (Healthcare Incentives Payment Pilot, or HIPP). The mutual accountability program will launch in 2016, so preliminary results will be available in late 2017.

b. ***Bridges to Excellence (BTE)***. National and local CBGH studies confirm reductions in costs for patients whose physicians are recognized in the Bridges to Excellence program.

c. ***Leapfrog.*** A national program to reduce the incidence of early elective deliveries in the United States has reduced the incidence of Caesarian births and the attendant costs in Colorado and nationally.

d. ***Healthcare Bluebook.*** Studies show a reduction in costs to members and plans when employees are activated to shop for their "shoppable services" such as imaging and lab tests.

e. ***Negotiated price for hip and knee replacement surgery.*** Cost savings to the patient and to the plan will occur in 2015.

5. Where We See Waste in the System. The programs and analytics supported by the CBGH document two types of waste in health care:

a. ***Quality Waste***. Exemplifies the Institute of Medicine's conclusion that health care costs are driven by "quality waste" comprised of three components:

i. *Underuse* of some services (eg., primary and preventive care)

ii. *Overuse* of some services (eg., emergency departments, and "Choose Wisely" procedures)

iii. *Misuse* of some services/safety (eg., hospital errors and infections, drug interactions)

b. ***Pricing Waste***. In the Denver market alone, prices for routine, "commodity" services can range from 250% to as much as 1100%, primarily because of variations in facility fees. These kind of pricing variations appear without any justification in terms of improved value. In fact, the literature would suggest that the higher priced facilities have to charge more because of quality waste.

6. **Principal Barriers to Transparency?**

a. ***Insurer and provider reluctance to share negotiated prices***. Current contracting between health plans and employers focus on deep discounting instead of the true

cost of care. Prices are not made publicly available to permit patient choice and efficient markets.

b. ***Fee for service payment***. Current practices - whereby disparate providers are paid fee-for-service for various components of complex procedures – effectively make it impossible for a consumer to shop for anything more complex than a single lab test or radiology exam.

c. ***Global Fees/Payments***. While widely touted as the preferred model of payment for so-called "accountable care organizations" or ACOs, global payment (aka capitation) will actually further obscure both pricing and utilization information from consumers.

7. **What would you change to make things better related to cost?** We would recommend that employers change the way they purchase and provide health care services by employing two sets of "value-based" strategies:

   a. ***Value-Based Purchasing***. Value-based purchasing consists of numerous practices of which we would place the highest value on five specific and synergistic tactics:

      i. Bundled Payments. A reduced reliance on fee-for-service reimburse in favor of bundled payments for complex procedures for the reasons discussed above.

      ii. Transparency. So that both employers (at the contracting level) and enrollees (at point-of-service) can judge the value of the services they are purchasing.

      iii. A Retail Market. The current "business-to-business" model whereby large insurers create exclusive or preferred networks rewards both insurers and health systems for being big rather than being good. Many health care services – and much of healthcare's costs – can be provided on a retail or "business-to-consumer" basis where the focus is on consumer satisfaction and on which providers are rewarded for being good, not simply big.

      iv. Reference-Based Pricing. Enrollees – who typically access the health system only occasionally and oftentimes under some or even considerable emotional duress – cannot be expected to be good consumers all on their own. Employers need to do some of the basic homework for them including establishing "fair" or market-based pricing for the most commonly utilized services.

      v. Centers of Excellence. The most specialized types of services – including much tertiary care and all quaternary care – should be accessed only a centers of excellence with the most experience and best outcomes. For these types of services, employers should establish – either directly or through third-parties – preferred contracts.

   b. Value-Based Benefit Design

      i. Incentives to utilize high-value health services

      ii. Disincentives to utilize low-value health services

      iii. Adoption of shared decision making techniques

iv. Benefit designs to enhance advanced directives, palliative care, and better end of life benefits