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HEALTH CARE VALUE HUB

An introduction to:

Healthcare Value

What's the problem? What's the solution?

Lynn Quincy, Director
Sept 16, 2016
@LynnQuincy @HealthValueHub

Yes, THAT *Consumer Reports*

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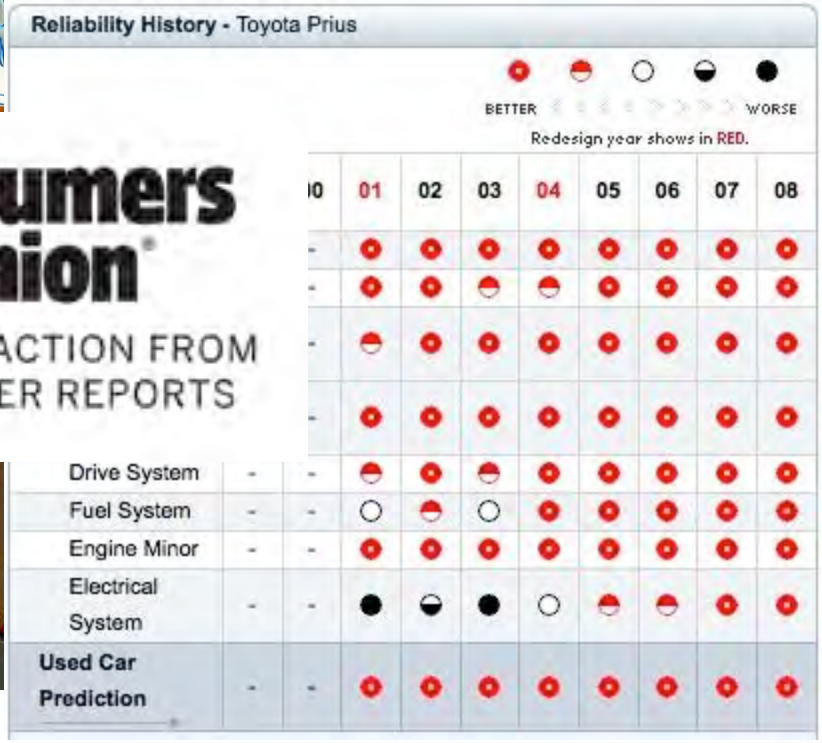


What is our “Healthcare Value Problem?”

Poor healthcare value is characterized by:

- High and rising healthcare prices
- Unwarranted variation in healthcare prices
- Unacceptable variation in healthcare quality
- Too little cost and quality transparency

Why should consumers care about poor healthcare value?

Healthcare Costs:
Top of Mind Concern for Consumers

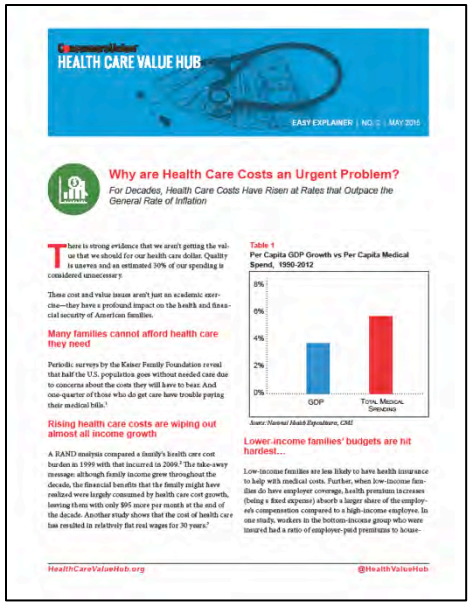
On both sides of political aisle, consumers feel strongly that "someone" – probably a government entity - should address high health care prices.

Consumers support a wide-range of solutions.

Consumers willing to take action.

Report available at*: http://consumersunion.org/consumer-views-on-health-costs-quality-and-reforms/*

Significant Consumer Harm Arises from Poor Health Care Value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EASY EXPLAINER | NO. 5 | MAY 2016

Why are Health Care Costs an Urgent Problem?

For Decades, Health Care Costs Have Risen at Rates that Outpace the General Rate of Inflation

There is strong evidence that we aren't getting the value that we should for our health care dollar. Quality is uneven and an estimated 30% of our spending is considered unnecessary.

These cost and value issues aren't just an academic exercise—they have a profound impact on the health and financial security of American families.

Many families cannot afford health care they need

Periodic surveys by the Kaiser Family Foundation reveal that half the U.S. population goes without needed care due to concerns about the costs they will have to bear. And one-quarter of those who do get care have trouble paying their medical bills.[1]

Rising health care costs are wiping out almost all income growth

A RAND analysis compared a family's health care cost burden in 1999 with that incurred in 2009.[2] The take-away message: although family income grew throughout the decade, the financial benefits that the family might have realized were largely consumed by health care cost growth, leaving them with only $95 more per month at the end of the decade. Another study shows that the cost of health care has resulted in relatively flat real wages for 30 years.[3]

Table 1
Per Capita GDP Growth vs Per Capita Medical Spend, 1990-2012

Source: National Health Expenditures, CMS

Lower-income families' budgets are hit hardest...

Low-income families are less likely to have health insurance to help with medical costs. Further, when low-income families do have employer coverage, health premium increases (being a fixed expense) absorb a larger share of the employee's compensation compared to a high-income employee. In one study, workers in the bottom-income group who were insured had a ratio of employer-paid premiums to house-

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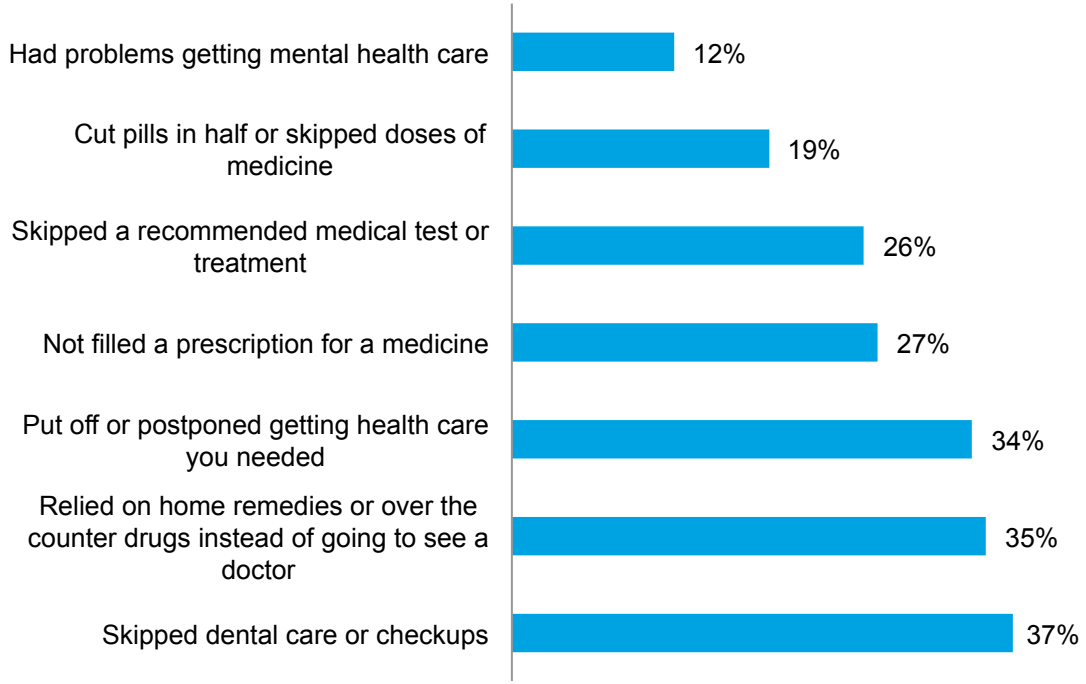
- Difficulty affording premiums and out-of-pocket expenses – sub-optimal healthcare
- Household resources diverted from food and housing
- Lower paychecks
- Stress and anxiety
- Medical harm
- Public resources diverted from other uses

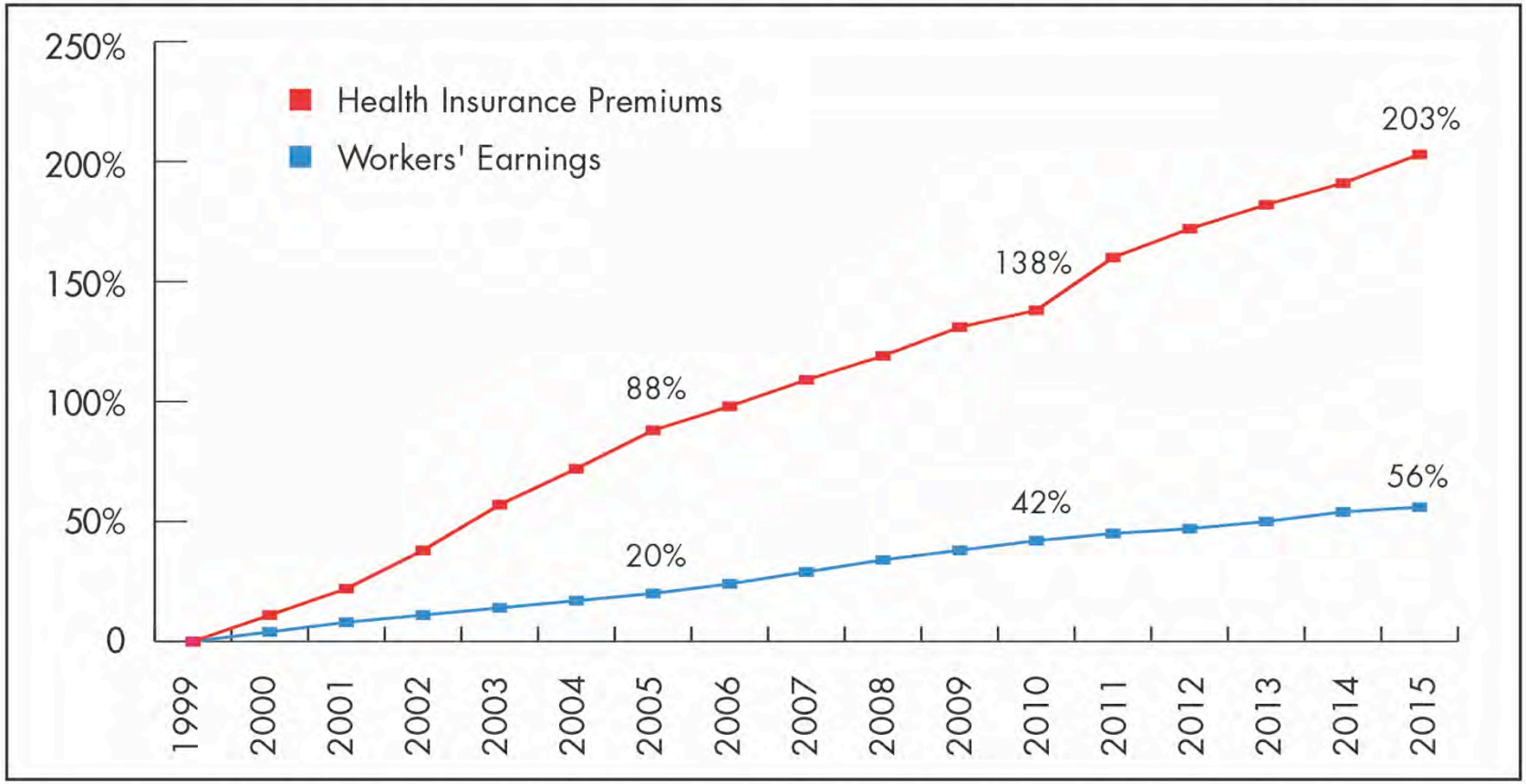
Delaying Care Because of Cost

Percent who say they or another family member living in their household have done each of the following in the past 12 months because of the cost:



Source: Kaiser Family Foundation *Health Tracking Poll* (conducted September 12-18, 2013). Totals reflect insured and uninsured adults.

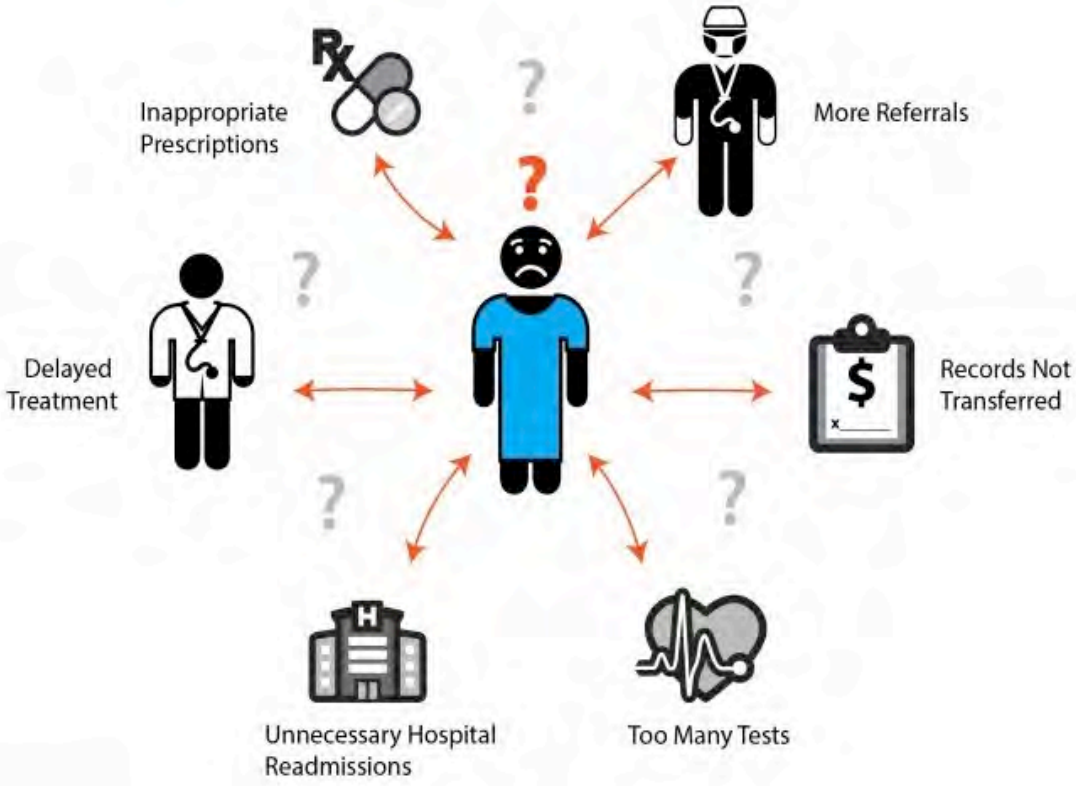
Cumulative Increases in Health Insurance Premiums and Workers' Earnings, 1999-2015



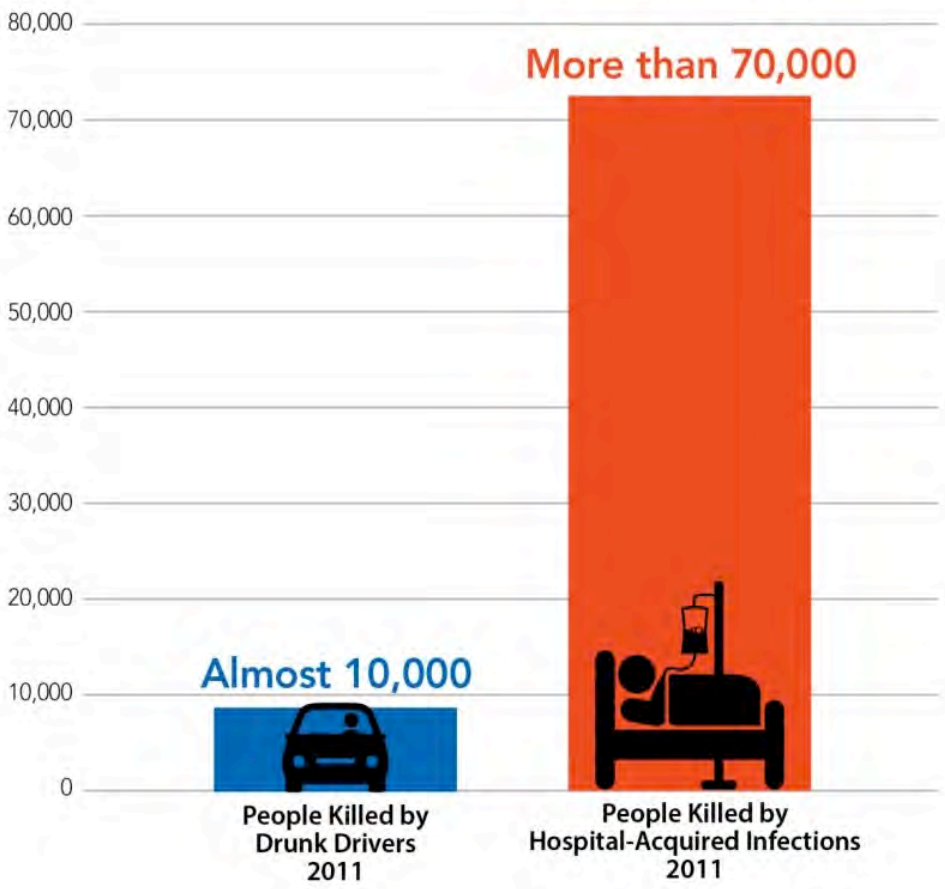
Source: Healthcare Value Hub, Rethinking Consumerism in Healthcare Benefit Design, *Research Brief No. 11 (April 2011). Author adaptation of Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2015 (April to April).*

Too Many Patients Have to Manage Their Own Care

Uncoordinated Care Results in Worse Outcomes, Higher Costs & Patient Frustration



Hospitals Can Be Dangerous



Every year in the U.S., drunk drivers kill almost **10,000** people, but hospital-acquired infections kill **over seven times** that many.

The CDC estimates these infections add **$45 billion** every year to hospital costs.

Clearly an issue advocates, policymakers and others need to address – but how?

Let’s start by unpacking what’s going on

What drives high healthcare spending?

Cost drivers come in many flavors

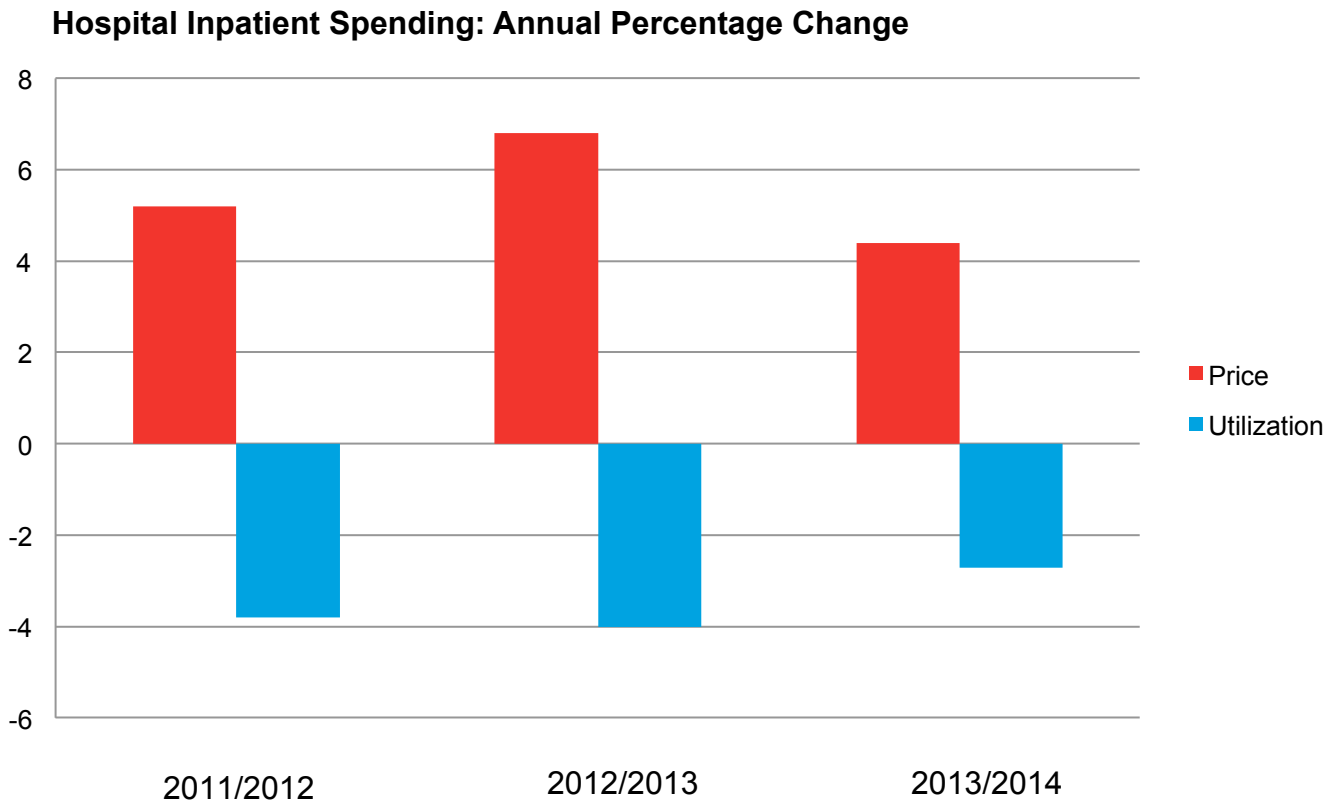
Type of Cost Driver	Description
Industry Segment	Highlights segments of the health care industry where spending has been increasing, like outpatient care
Demographic	Measures of the population, society, and general economy that appear to result in more spending on health care, like the aging of the population or increases in per capita income.
Health Condition	Measures of illness or other health conditions that have changed over time in excess of general demographic trends, like the increasing prevalence of diabetes.
Line Item	Increasing amounts actually being spent by health care providers in their operating budgets, like increased spending on new medical technology.
Policy Drivers	Public policy and health system practice can contribute to the cost of health care, like allowing hospital consolidations that result in near monopolies.

Adapted from Doug Hall, *Will the Real "Cost Drivers" Please Stand Up? The Problem of Identification,* November 2004.

Four Big Themes

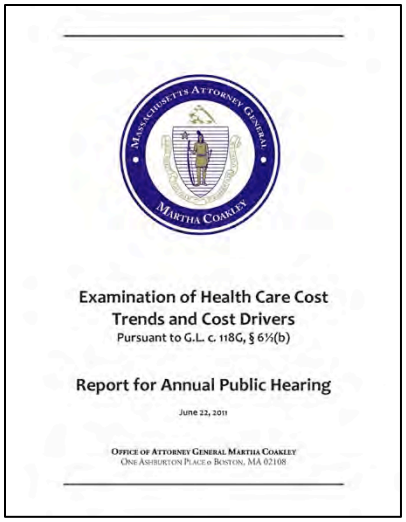
- **Rising unit prices** are our biggest problem.
- **Waste** - consuming services we shouldn't - also important.
- **Lifestyle considerations** important -- should address for consumer quality of life -- but won't solve spending problem unless we also address unit prices.
- A few **minor drivers** often mistakenly cited as important drivers.

Rising unit prices drive healthcare spending growth; increases in utilization a less important factor



Source: *2014 Health Care Cost and Utilization Report Appendix*, HCCI, Oct 2015

Market power is a major reason for unit price growth



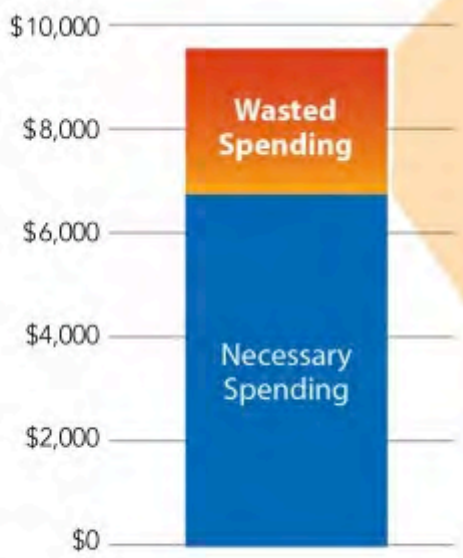
Massachusetts AG scrutinized the normally "secret" provider contracts and found:

…wide disparities in prices are not explained by differences in quality, complexity of services, or other characteristics that might justify variations in prices paid to providers. Instead, prices reflect the ***relative market leverage*** *of health insurers and health providers.*

Source: Office of Attorney General Martha Coakley, *Examination of Health Care Cost Trends and Cost Drivers*, June 22, 2011.

Approximately 1 in 3 Health Care Dollars is Waste

Can We Afford This?



Average U.S. Healthcare Spending per Person in 2014

$9,700

Unnecessary Services *Example: Duplicate Tests*		**$800**
Excess Administrative Costs *Example: Billing Errors*		**$720**
Inefficient Care Delivery *Example: Test Results Not Shared*		**$495**
Inflated Prices *Example: Excessive Profits*		**$400**
Fraud *Example: False Claims*		**$285**
Prevention Failures *Example: Missed Flu Shot*		**$210**

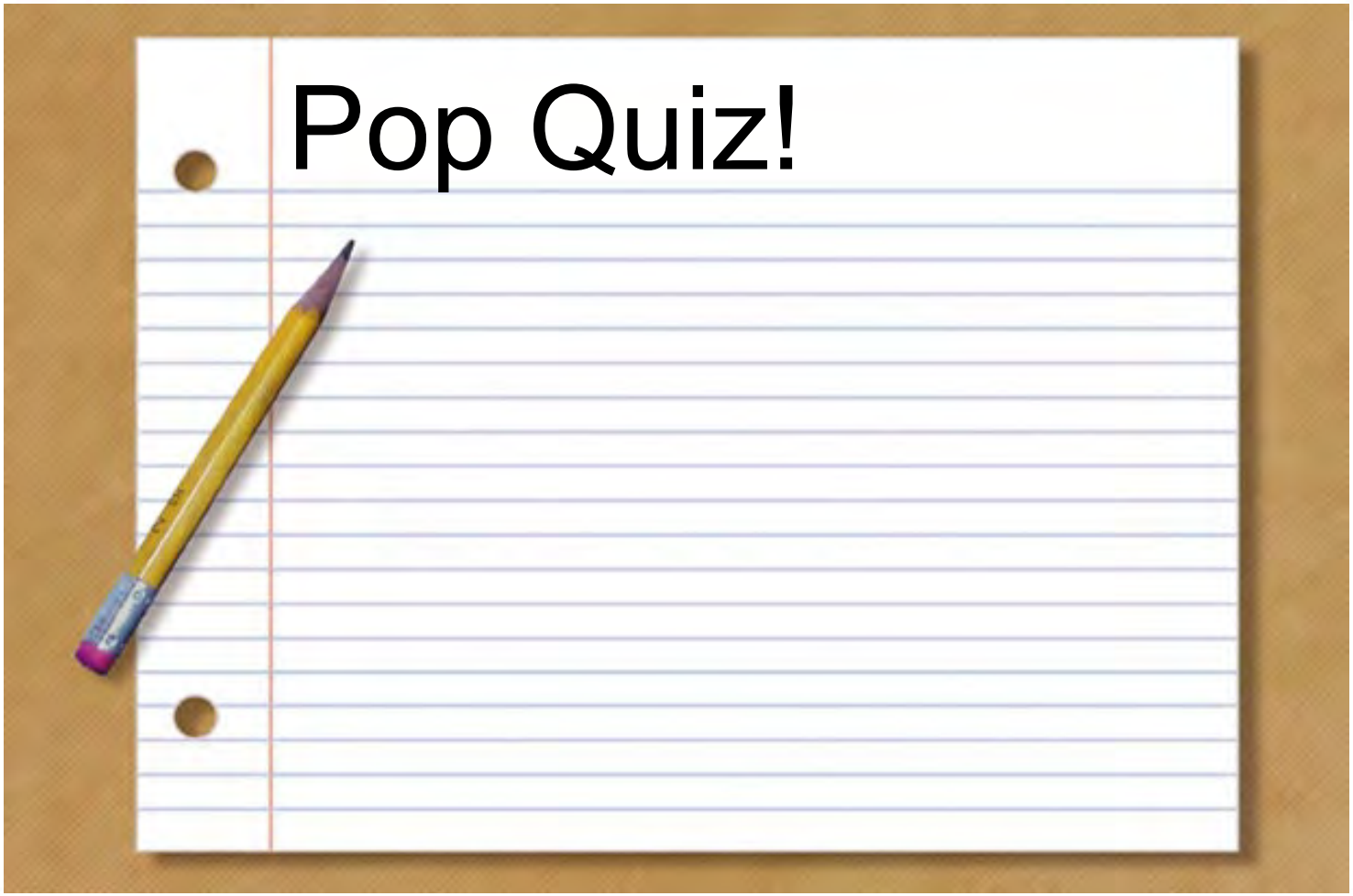
Total Wasted Spending per Person $2,910

Lifestyle Factors

Smoking – a minor driver – we have low rates in this country

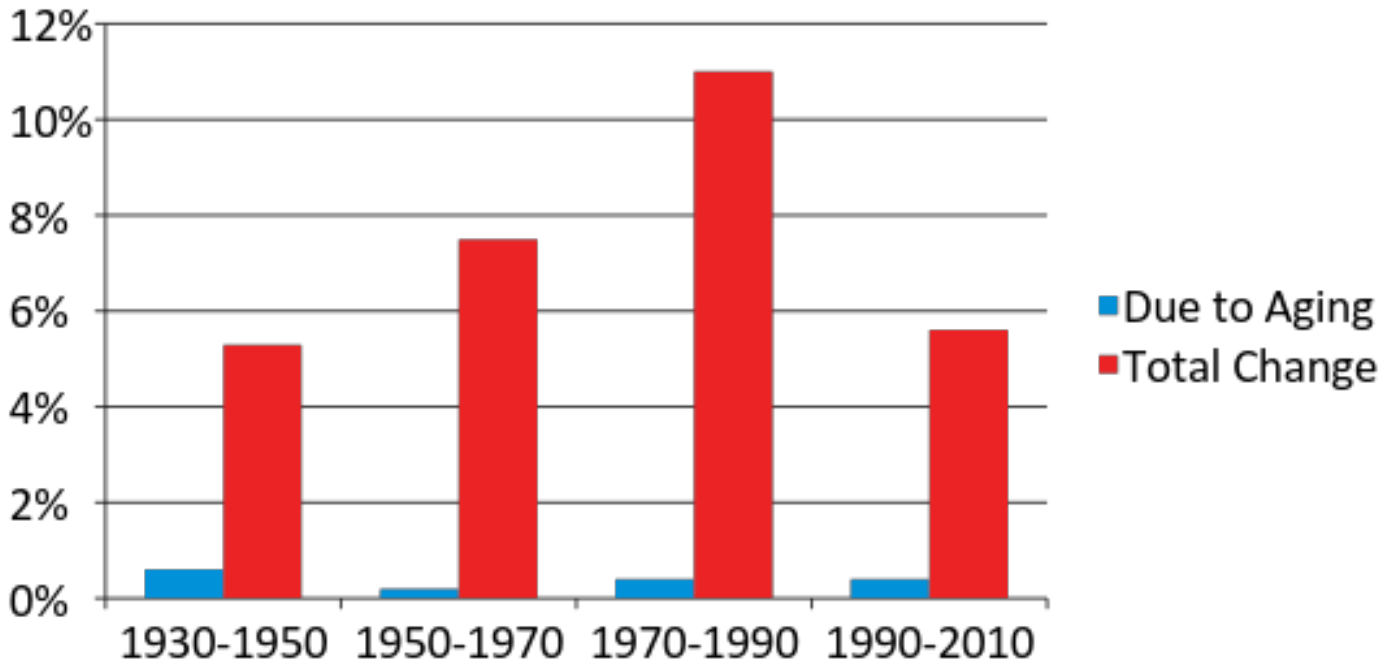
Obesity – not a driver per se but the resulting chronic diseases …

Chronic diseases – reducing disease prevalence a critical quality-of-life issue but unless we address cost per case, will not reduce growth in spending


Pop Quiz!

Aging of the population is NOT a significant cost driver

Average Annual Change in Per Capita Health Spending



See: Dale H. Yamamoto, *Health Care Costs from Birth to Death,* June 2013

What can we do to provide consumers with better healthcare value?

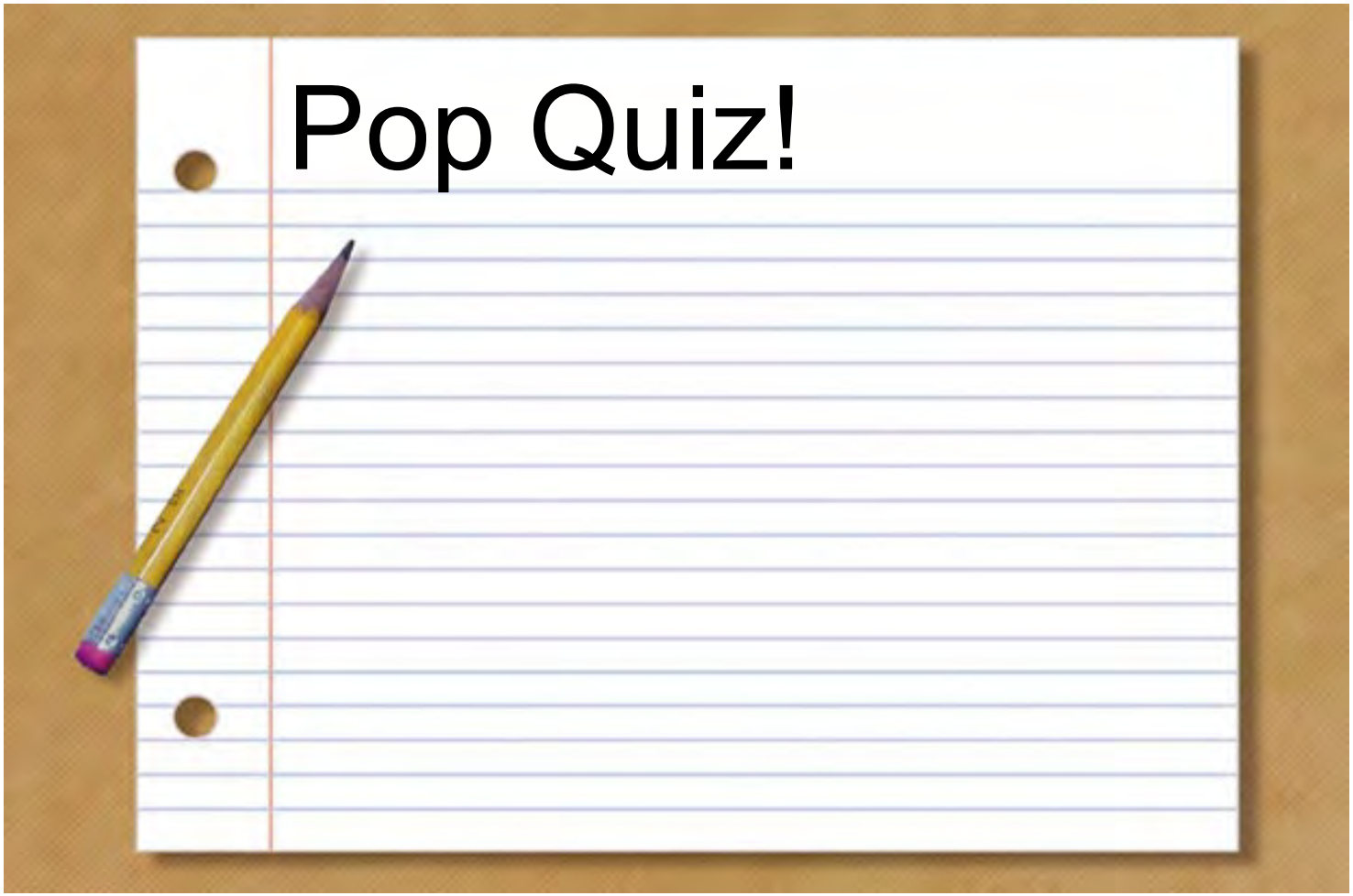
Over 50 interventions have been proposed (!)

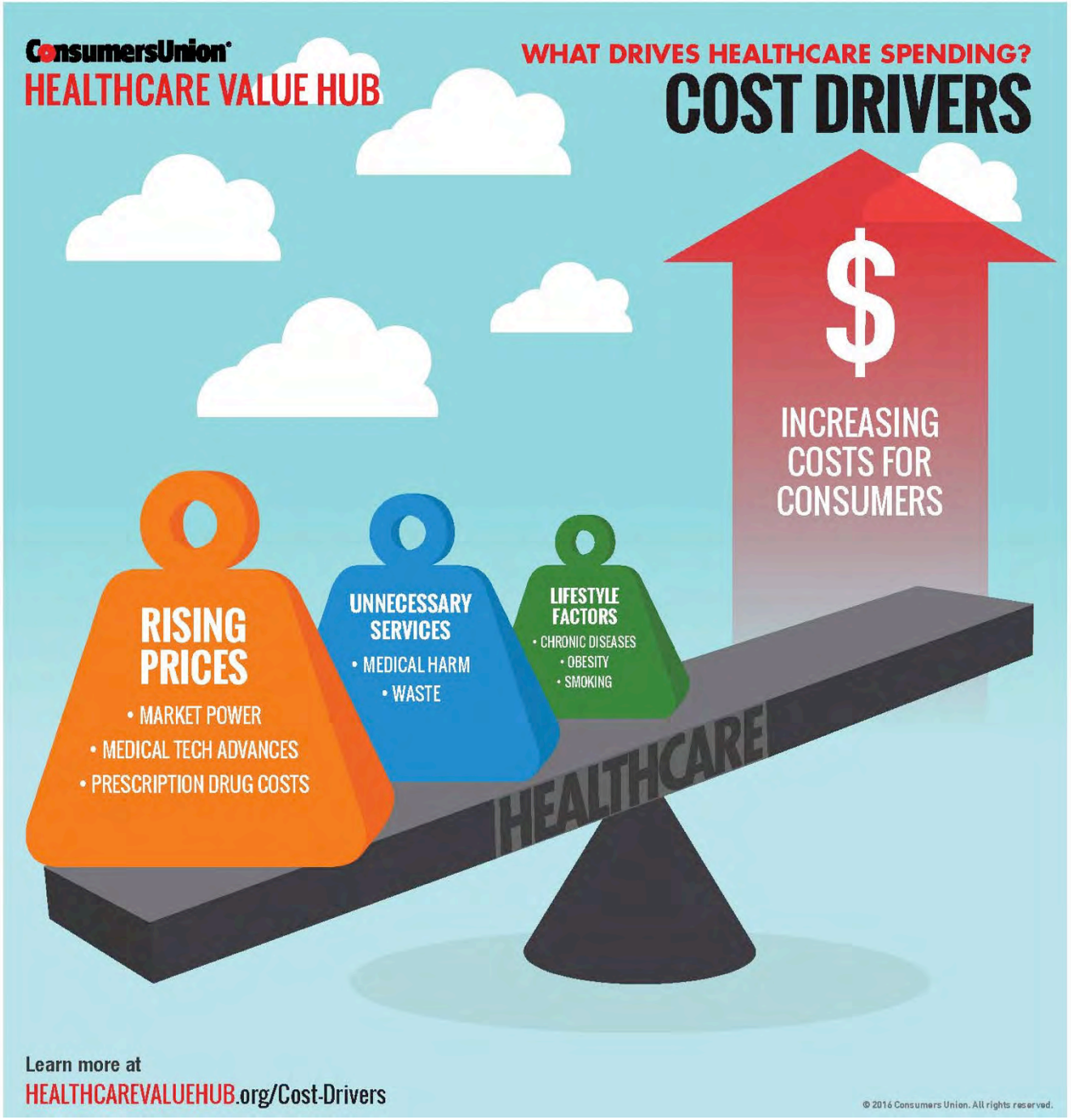
It's helpful to group them by general approach:

- Transparency
- Changing Incentives
- More comprehensive reform of clinical care
- Population health measures

To find the "correct" intervention, you must match it to:

1. **The right system problem**
2. **The right system actor**


Pop Quiz!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WHAT DRIVES HEALTHCARE SPENDING?
COST DRIVERS
$
INCREASING COSTS FOR CONSUMERS
RISING PRICES
• MARKET POWER
• MEDICAL TECH ADVANCES
• PRESCRIPTION DRUG COSTS
UNNECESSARY SERVICES
• MEDICAL HARM
• WASTE
LIFESTYLE FACTORS
• CHRONIC DISEASES
• OBESITY
• SMOKING
HEALTHCARE
Learn more at
HEALTHCAREVALUEHUB.org/Cost-Drivers
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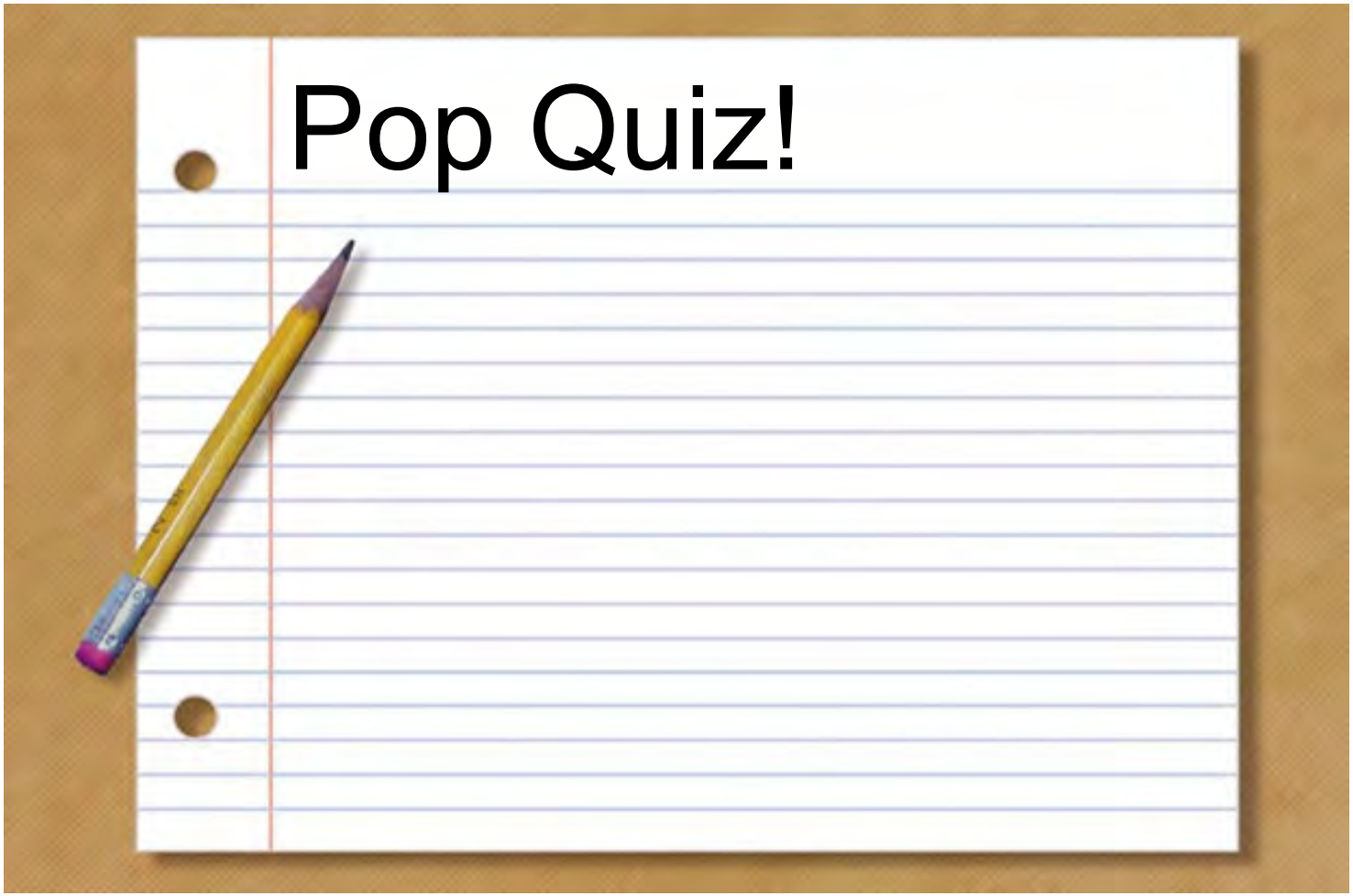
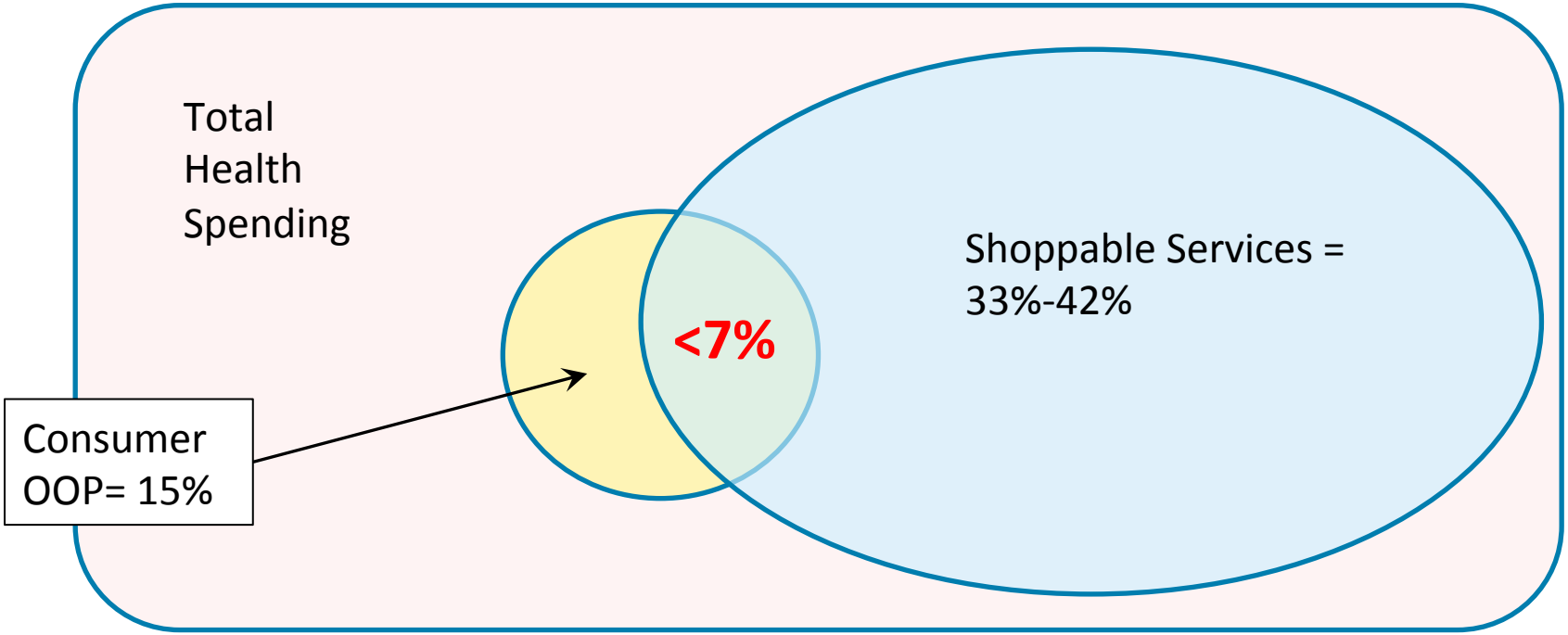

Pop Quiz!

System actors:

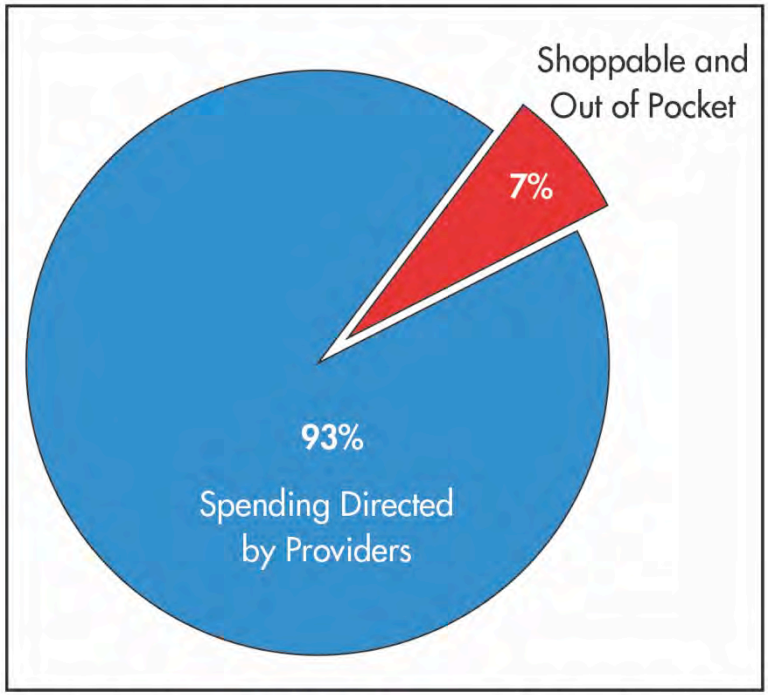
Less than 7% of total private health spending is "shoppable" and paid out-of-pocket by consumers



Sources: *Spending on Shoppable Services in Health Care*, HCCI, March 2016 and White and Eguchi, *Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle*, NIHCR Research Brief No. 18 (October 2014).

Most Healthcare Dollars Are Directed by Physicians

Consumers Direct a Small Percentage of Healthcare Spending



Source: Healthcare Value Hub, Rethinking Consumerism in Healthcare Benefit Design, *Research Brief No. 11 (April 2011). Adapted from Health Care Cost Institute,* Spending on Shoppable Services in Health Care, *(March 2016).*

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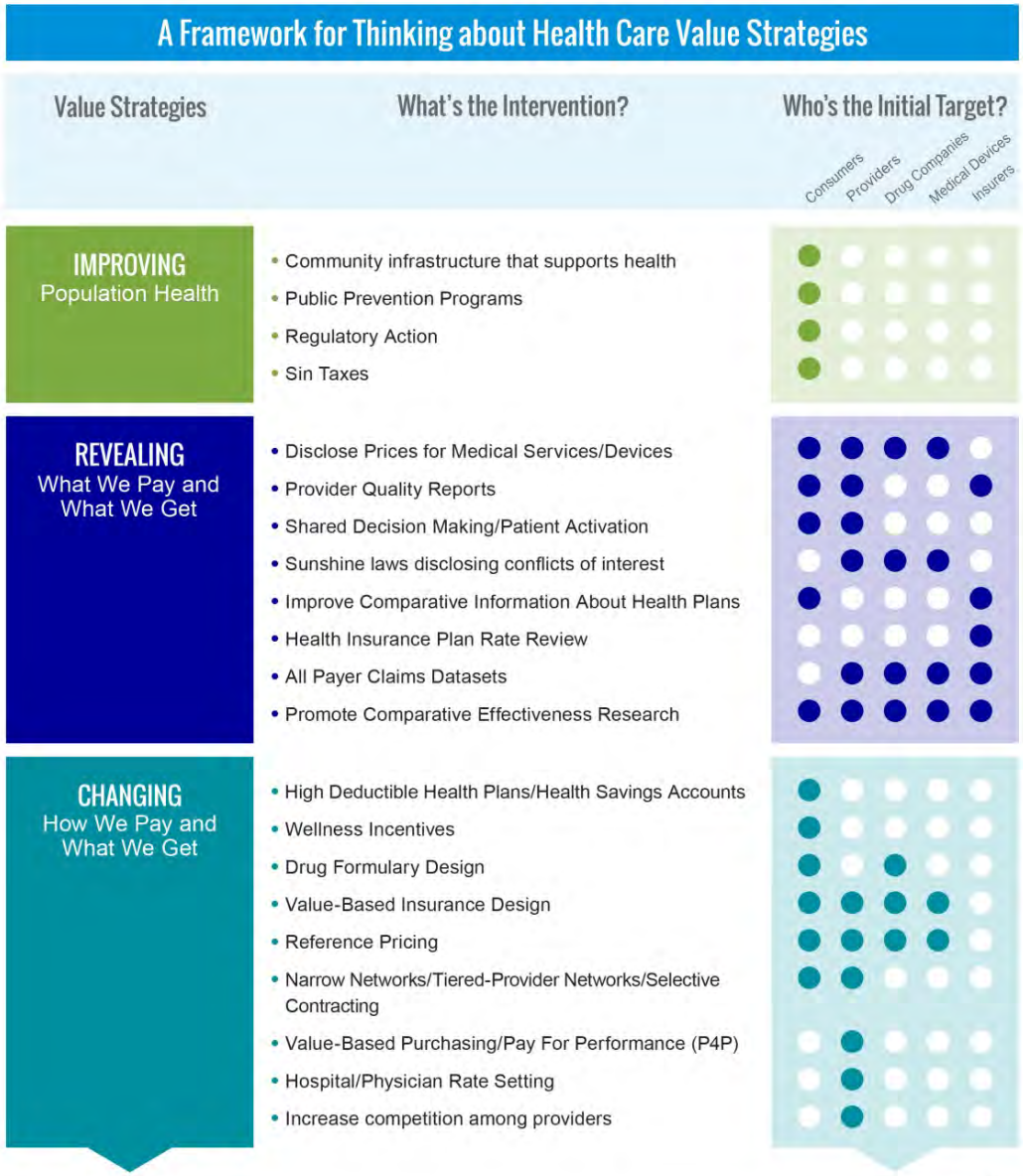
A Framework for Thinking about Health Care Value Strategies



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Selected Interventions for Discussion Today

Consumer-Directed

- High Deductible Health Plans --
- Value Based Insurance Design (VBID)

Provider-Directed

Payment Reform

- Bundled Payment
- Value-Based Purchasing
- Capitation vs Total Cost of Care

Better Care Coordination

- Patient Centered Medical Homes (PCMH)
- Accountable Care Organizations (ACOs)

Spending Targets

- Global Budgeting
- Certificate of Need

Population Health Measures for High Cost- High Need Patients

Consumer-Directed Interventions: High-Deductible Health Plans (HDHPs)?

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RESEARCH BRIEF NO. 11 | APRIL 2016

Rethinking Consumerism in Healthcare Benefit Design

High healthcare costs are a concern for consumers and payers alike. Insurance premiums have risen faster than wages and the economy in general for nearly two decades. High levels of health spending crowds out other important spending. For households, this means lower wages and less money for competing priorities. For state and national governments, it means less to spend on education, infrastructure and other public needs. There is consensus that we can cut back on waste in the system (including prices that are too high) in order to reduce spending without harming our health outcomes.

An oft-used strategy to address high healthcare costs are insurance products called high-deductible health plans, or more generally, consumer-directed healthcare. The basic idea is that by requiring consumers to pay substantial cost sharing these plan designs will incentivize consumers' to extract better value from the healthcare marketplace, helping to stem the tide of rising healthcare costs and reducing the use of low-value care. Nearly half of Americans with employer-provided insurance were required to meet an individual deductible of more than $1,000 in 2015, and many plans go much higher, with deductibles in the $5,000–$6,500 range.[1]

There's just one problem—we have little evidence to suggest that these high-deductible plan designs work. To control spending and bring better value to our healthcare system, we need a new vision for what the consumer's role should be.

SUMMARY

For decades, rising healthcare costs have strained household, employer and government budgets. A strategy often proposed to address these high costs is to give consumers more "skin in the game," through high-deductible health plans. When accompanied by shopping aids, these plans are sometimes called consumer-directed health plans. But a wealth of evidence suggests that high-deductible health plans are not leading to better value in our healthcare system. What's more, unaffordable cost sharing causes considerable consumer harm. Instead, efforts to address high prices and promote high-value care must have a strong provider-directed component, because providers direct treatment plans and steer almost all of our healthcare spending. Our country needs to rethink the role of the consumer in healthcare to be fair, patient-centric and evidence-based. Consumers should be empowered with timely, accurate and actionable information to help make decisions about their care and not have their choices curtailed due to unaffordable cost sharing.

The Theory Behind Consumer-Directed Healthcare and High-Deductible Health Plans

Whether described as a high-deductible health plan or consumer-directed healthcare—either paired with a tax advantaged account like an HRA or an HSA[2] or not—the theory is the same: If consumers face the consequences of their health spending they will spend their dollars more wisely. With up to 30 percent of healthcare spending classified as "waste" by the Institute of Medicine,[3] the goal is for consumers to cut out unnecessary or "wasteful" spending and put downward pressure on prices.

Even When These Plans Save Money, It's Not Because Enrollees Become Wise Shoppers

High-deductible health plans have been associated with lower premiums (compared to plans featuring lower

Compared to more generous coverage, premiums are lower BUT:

- Patients reduce both necessary and unnecessary care
- Patients don't price shop
- Patients don't shop based on quality

HDHP: What's the Bottom Line?

HDHPs are the WRONG approach to addressing high health care costs

Providers need to be the focus of cost-containment efforts

HDHPs need to be replaced with more consumer-centric, evidence-based benefit designs:

- VBID and affordable cost-sharing
- Reference pricing
- High value provider networks
- Strong provider and treatment-specific quality signals

Consumers STILL deserve actionable, reliable information on price and quality

Consumer-Directed Interventions: VBID

Value-based Insurance Design: "clinically nuanced benefit design"

Lower cost sharing for high-value services

Higher cost sharing for low-value services

Advocacy Considerations for Consumer-Friendly VBID:

- Focus on High-Value Care
- Ensure Benefits are Based on Evidence
- Don't Confuse VBID with Wellness Programs

Consumer-Directed Interventions: VBID

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EASY EXPLAINER | NO. 5 | JULY 2016

Value-Based Insurance Design: Potential Strategy for Lower Costs, Increased Quality

Health insurance plans have long included various forms of consumer cost sharing, in the form of deductibles, copays and coinsurance. Value-based insurance design (VBID) introduces a new twist by aligning the amount of cost sharing with the relative value of care: reducing or eliminating cost sharing for high-value care while increasing cost sharing for low-value care. By reducing financial barriers, the goal is to incentivize consumers to make better healthcare treatment decisions.

VBID was originally conceived as a way to encourage patients with chronic conditions, such as diabetes, to adhere to long-term treatment plans. Insurers have since expanded VBID to encourage the use of preventive services and other types of high-value care. The Affordable Care Act (ACA) embraced this concept by requiring that key preventive services be provided with no patient cost sharing. More recently, HHS announced a Medicare Advantage VBID trial in seven states starting in 2017.

By reducing patient cost sharing—providing a "carrot"—insurers hope to incentivize the use of high-value care, ultimately leading to better health outcomes and lower costs. Ideally any savings associated with having healthier beneficiaries would then be passed onto consumers in the form of lower premiums. In contrast, by increasing cost sharing—providing a "stick"—VBID may be used to discourage the use of healthcare that is deemed low value. Here, the target is not patient health, but rather preventing wasteful spending on services that are either over-used or not considered cost effective. An example of low-value care would be prescribing an antibiotic for a viral sinus infection or performing an MRI for back pain that has not been given time to heal.

What Does the Evidence Say?

Surprisingly, the response to lower cost-sharing incentives under VBID is not as strong as originally predicted. An analysis of thirteen studies found an average three percent increase in treatment adherence among patients with chronic conditions. These results indicate that factors other than, or in addition to, cost continue to prevent many consumers from using the high-value care that VBID aims to promote. In many cases, consumers may simply lack the information, expertise or motivation to change their behavior. Because of this, the benefits of VBID "carrots" have largely accrued to consumers who are already relatively health conscious and treatment compliant.

Perhaps for these reasons, the evidence is mixed on the effect of VBID on health outcomes. Although some studies show health improvements, others found improved treatment adherence did not necessarily lead to better clinical outcomes.

Early but promising research shows that employing VBID as one piece of a larger and more comprehensive strategy can encourage healthy behavior. Studies indicate that plans are more effective at boosting treatment compliance when they provide more generous benefits, target high-risk patients, include wellness programs and employ mail-order pharmacies.

The other side of VBID—providing a "stick" to discourage lower value care—is rarely implemented and for the most part unstudied. While it is well understood that higher cost-sharing discourages the use of care, it is not yet known

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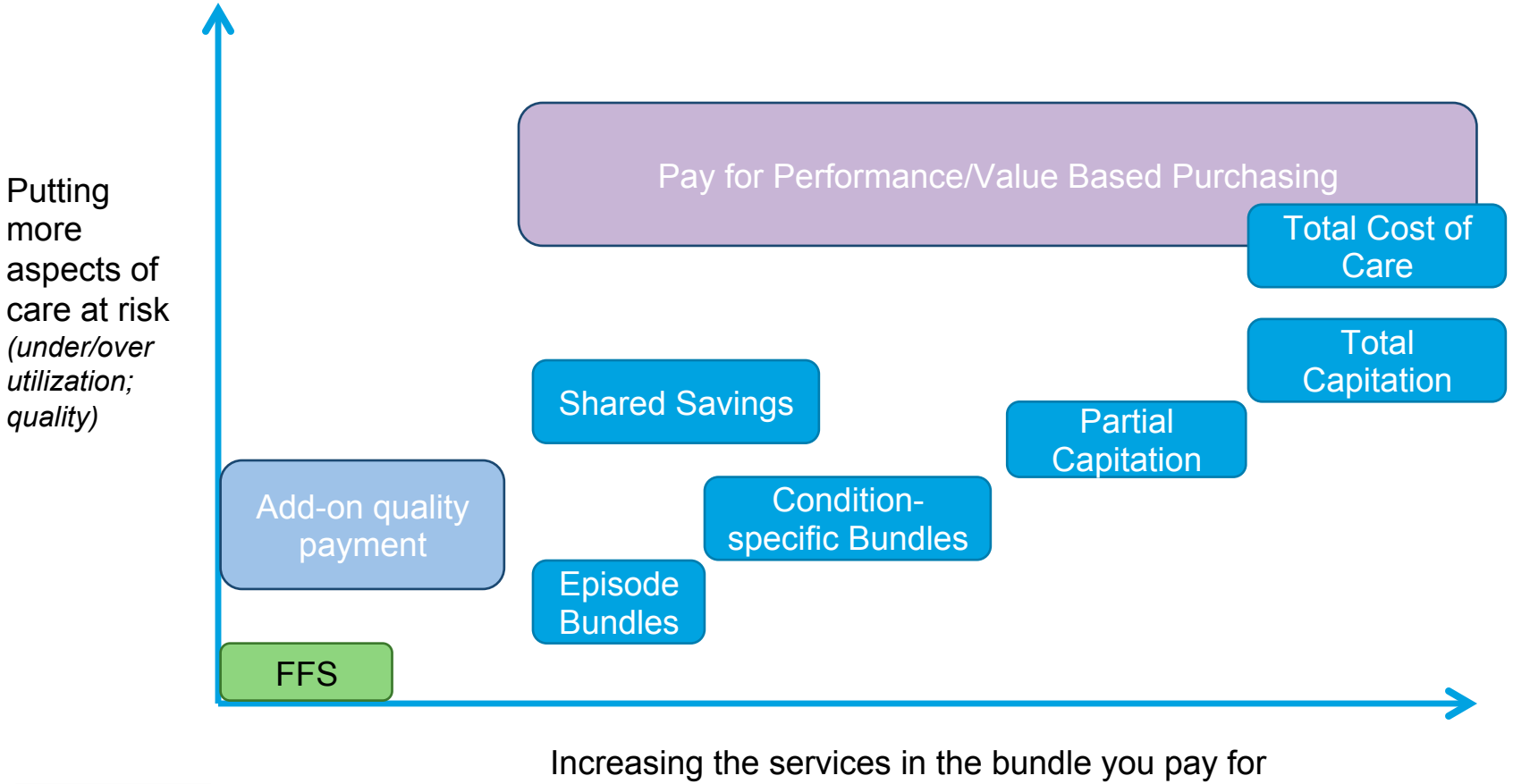
What Does the Evidence Say?

- Surprisingly, the response to lower cost-sharing incentives under VBID is not as strong as originally predicted.
- Because of this, the benefits of VBID "carrots" have largely accrued to consumers who are already relatively health conscious and treatment compliant.
- VBID "stick"s (to discourage lower value care) are rarely implemented and for the most part unstudied. While it is well understood that higher cost-sharing discourages the use of care, it is not yet known whether patients will respond in the nuanced way that VBID intends, as opposed to reducing the use of care indiscriminately.

Provider-Directed Interventions: Payment Reform



Provider-Directed Interventions: Bundled Payments/Capitation

A fixed payment that covers all services delivered by provider(s) for all services to treat:

- a given condition (diabetes); or
- provide a given treatment (knee replacement) or
- to care for a population for a year (capitation).

Pros: Incentive for providers to avoid overprescribing and the overutilization of services.

Cons: Providers may underutilize services. Strong outcome metrics can counteract this concern.

Provider-Directed Interventions: Value-Based Purchasing

Also known as *Value-Based Reimbursement* and *Pay-for-Performance*, this form of payment reform includes incentives that reward outcomes.

Incentives may reward for (1) measuring and reporting comparative performance and/or (2) meeting performance/quality targets.

Pros: Rewarding quality should improve outcomes by driving coordination and patient centered care; counteracts the tendency to undertreat when bundling.

Cons: May incentivize providers to avoid complex patients.

Full Capitation vs. Total Cost of Care

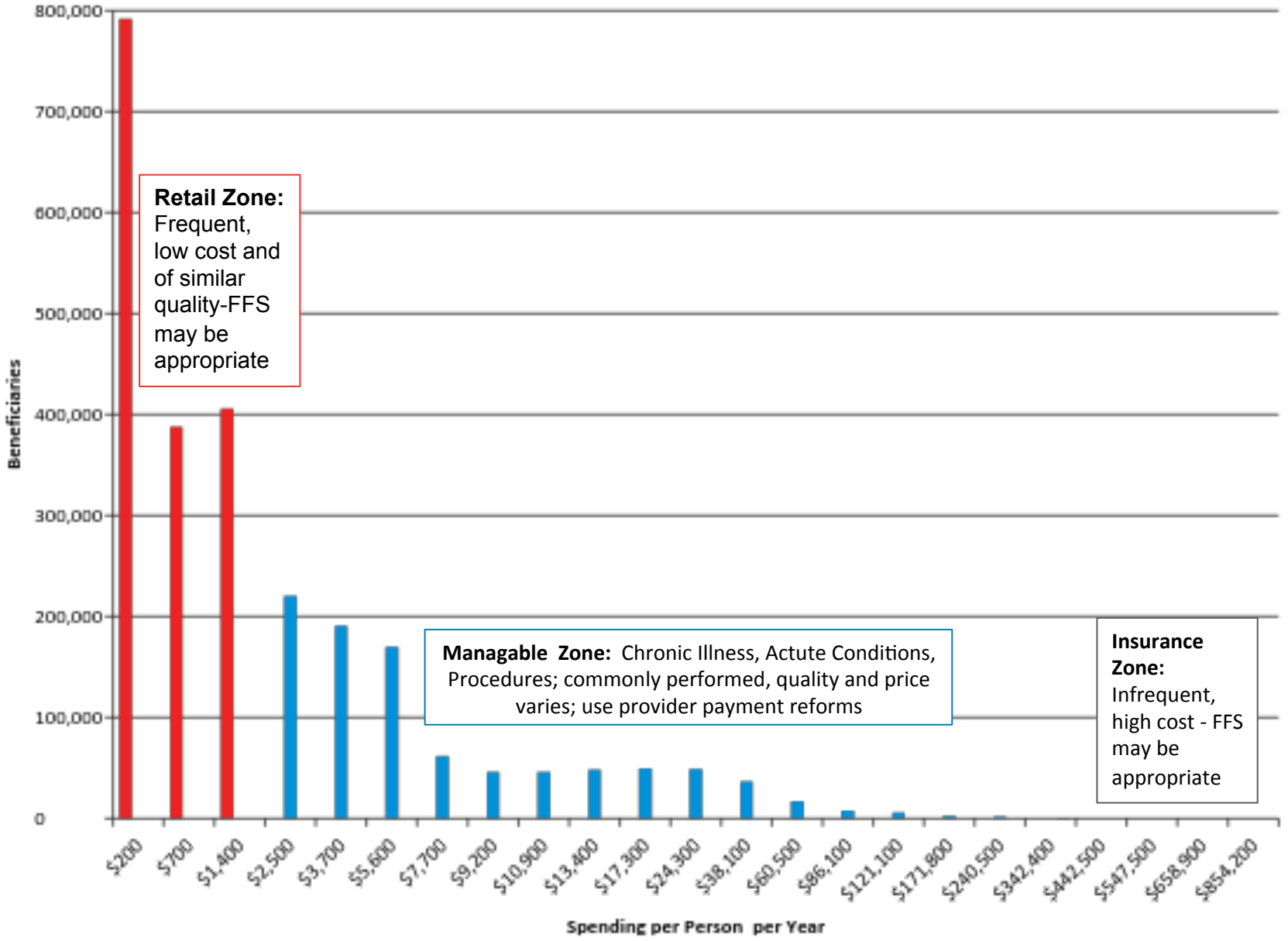
- **Full Capitation**

Provider is paid a fixed rate per person per month, usually prospectively, to cover all care within a specified set of services and administrative costs without regard to the actual number of services provided.

- **Total Cost of Care**

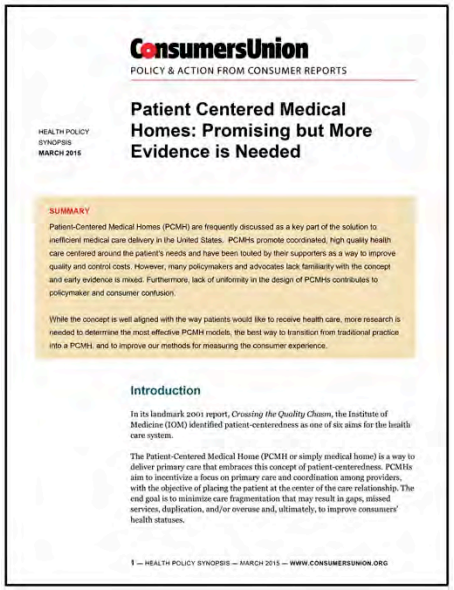
Very similar to capitation, but incorporates quality measurement and uses of more sophisticated risk-adjustment methodologies.

A Variety of Provider Payment Approaches Can Be Appropriate



Source: Adapted, with permission, from HCI3 graphic.

Provider-Directed Interventions: Patient Centered Medical Home (PCMH)



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HEALTH POLICY SYNOPSIS
MARCH 2015

Patient Centered Medical Homes: Promising but More Evidence is Needed

SUMMARY

Patient-Centered Medical Homes (PCMH) are frequently discussed as a key part of the solution to inefficient medical care delivery in the United States. PCMHs promote coordinated, high quality health care centered around the patient's needs and have been touted by their supporters as a way to improve quality and control costs. However, many policymakers and advocates lack familiarity with the concept and early evidence is mixed. Furthermore, lack of uniformity in the design of PCMHs contributes to policymaker and consumer confusion.

While the concept is well aligned with the way patients would like to receive health care, more research is needed to determine the most effective PCMH models, the best way to transition from traditional practice into a PCMH, and to improve our methods for measuring the consumer experience.

Introduction

In its landmark 2001 report, *Crossing the Quality Chasm*, the Institute of Medicine (IOM) identified patient-centeredness as one of six aims for the health care system.

The Patient-Centered Medical Home (PCMH or simply medical home) is a way to deliver primary care that embraces this concept of patient-centeredness. PCMHs aim to incentivize a focus on primary care and coordination among providers, with the objective of placing the patient at the center of the care relationship. The end goal is to minimize care fragmentation that may result in gaps, missed services, duplication, and/or overuse and, ultimately, to improve consumers' health statuses.

1 — HEALTH POLICY SYNOPSIS — MARCH 2015 — WWW.CONSUMERSUNION.ORG

- **A model of health care delivery structured around primary care that emphasizes coordinated, integrated care, and the patient's care experience.**
- **PCMHs seek to address the highly fragmented, specialist-driven care.**
  - While evidence is mixed, savings may be realized from improved health statuses, less reliance on specialists and hospitalizations, and avoiding duplication and overuse of services.

PCMHs (and ACOs) are more than payment reform initiatives

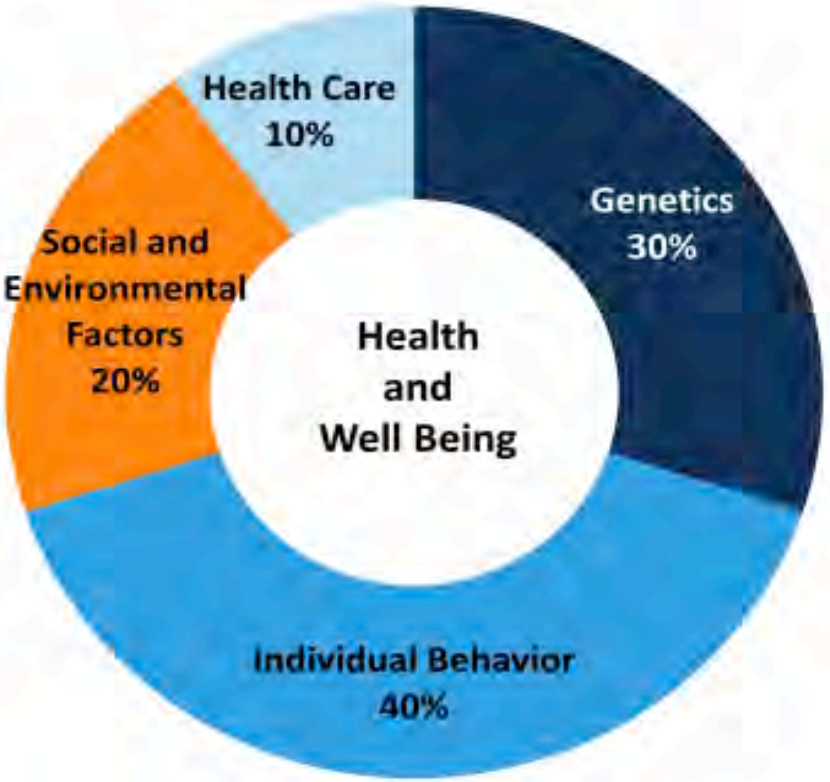
- **These delivery system reform models DO bundle together services, include quality targets and almost always include financial incentives.**
  - Financial incentives must not be mis-aligned
  - Correct financial incentives can help ensure success
- **But the models go further.** Clinical and non-clinical provider integration is expected, along with an overarching organizational structure that strives to ensure care is coordinated and patient centered.

PCMH vs. ACO

PCMH	ACO
Primary Care Services	Primary and Secondary Services
Better care coordination, patient centered	Better care coordination, patient centered
Provider payment likely to include a bonus for hitting quality targets, along with payments that reimburse for new activities.	Likely to include up and downside shared savings, often risk adjusted, with quality bonuses also possible.

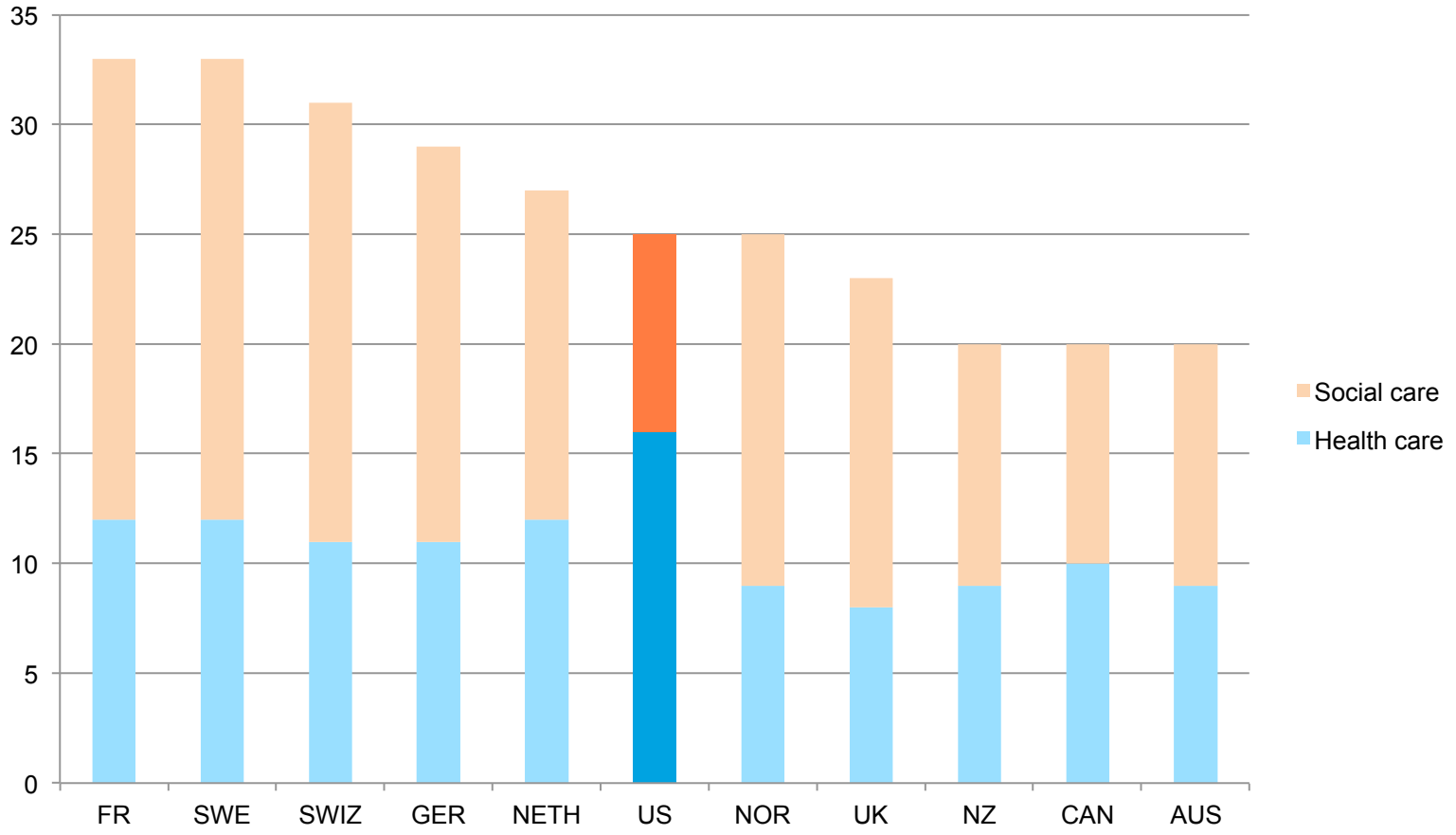
Looking beyond the clinical setting - social determinants of health

Impact of Different Factors on Risk of Premature Death



SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

Health and Social Care Spending as a Percentage of GDP



Note: GDP refers to gross domestic product.
Source: E.H. Bradley and L.A. Taylor, *The American Health Care Paradox: Why Spending More is Getting Us Less*, Public Affairs, 2013.

What are community health strategies?

Designed to reach people outside of traditional health care settings. For example:

- Schools
- Worksites
- Healthcare facilities
- Communities

Seek to change aspects of the physical, social, organizational, and even political environments in order to eliminate or reduce factors that contribute to health problems or to introduce new elements that promote better health.

Coming soon: Community Health Strategies for high-cost, high need patients - a Triple Play?

- Lower healthcare spending?
- Better outcomes?
- Reduced disparities?

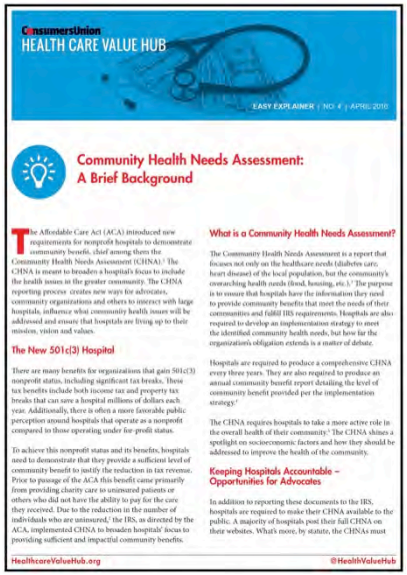
Jeepers, this is important! Are there resources to help me work on this issue?

What is the Healthcare Value Hub?

With support from the Robert Wood Johnson Foundation:

- **We monitor, synthesize, translate and disseminate evidence about interventions intended to improve value for our health care dollar.**

- **We support and connect consumer advocates across the U.S., providing comprehensive fact-based information to help them advocate for change, and networking them to researchers and other resources.**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EASY EXPLAINER | NO. 4 | APRIL 2018

Community Health Needs Assessment: A Brief Background

The Affordable Care Act (ACA) introduced new requirements for nonprofit hospitals to demonstrate community benefit, chief among them the Community Health Needs Assessment (CHNA).[1] The CHNA is meant to broaden a hospital's focus to include the health issues in the greater community. The CHNA reporting process creates new ways for advocates, community organizations and others to interact with large hospitals, influence what community health issues will be addressed and ensure that hospitals are living up to their mission, vision and values.

The New 501(c)(3) Hospital

There are many benefits for organizations that gain 501(c)(3) nonprofit status, including significant tax breaks. These tax benefits include both income tax and property tax breaks that can save a hospital millions of dollars each year. Additionally, there is often a more favorable public perception around hospitals that operate as a nonprofit compared to those operating under for-profit status.

To achieve this nonprofit status and its benefits, hospitals need to demonstrate that they provide a sufficient level of community benefit to justify the reduction in tax revenue. Prior to passage of the ACA this benefit came primarily from providing charity care to uninsured patients or others who did not have the ability to pay for the care they received. Due to the reduction in the number of individuals who are uninsured,[2] the IRS, as directed by the ACA, implemented CHNA to broaden hospitals' focus to providing sufficient and impactful community benefits.

What is a Community Health Needs Assessment?

The Community Health Needs Assessment is a report that focuses not only on the healthcare needs (diabetes care, heart disease) of the local population, but the community's overarching health needs (food, housing, etc.).[3] The purpose is to ensure that hospitals have the information they need to provide community benefits that meet the needs of their communities and fulfill IRS requirements. Hospitals are also required to develop an implementation strategy to meet the identified community health needs, but how far the organization's obligation extends is a matter of debate.

Hospitals are required to produce a comprehensive CHNA every three years. They are also required to produce an annual community benefit report detailing the level of community benefit provided per the implementation strategy.[4]

The CHNA requires hospitals to take a more active role in the overall health of their community.[5] The CHNA shines a spotlight on socioeconomic factors and how they should be addressed to improve the health of the community.

Keeping Hospitals Accountable – Opportunities for Advocates

In addition to reporting these documents to the IRS, hospitals are required to make their CHNA available to the public. A majority of hospitals post their full CHNA on their websites. What's more, by statute, the CHNAs must

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Resources

- Research Briefs, "Easy Explainers"
- Links to key studies, curated news
- Graphics/Infographics
- Glossaries
- Webinar Slides/Recording
- Consumer stories (w/ CU.org)
- Custom webinars

All available at: HealthcareValueHub.org

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Sign Up!

Thank you!

Contact Lynn Quincy at lquincy@consumer.org
with your follow-up questions.

Sign up for our Oct. 14 Webinar: ***All About Data: How to Supercharge Your Advocacy with State-Level Data***

Visit us at *HealthcareValueHub.org and ConsumersUnion.org*