Roadmap to a High-Value Health System

Addressing California's Healthcare Affordability Crisis

A Bay Area Council
Economic Institute Report

October 2011

Bay Area Council Economic Institute

201 California Street, Suite 1450, San Francisco, CA 94111

(415) 981-7117 • Fax (415) 981-6408

www.bayareaeconomy.org • bacei@bayareacouncil.org

Roadmap to a High-Value Health System

Addressing California's Healthcare Affordability Crisis

A Bay Area Council
Economic Institute Report by

Micah Weinberg, PhD
Senior Fellow
Bay Area Council Economic Institute

October 2011

Acknowledgements

The author would like thank the following people for their helpful feedback on early drafts of this document: Greg Adams of Kaiser Permanente, Alain Enthoven of Stanford University, Linda Galliher of the Bay Area Council, Michael Johnson of Blue Shield of California, Gerald Kominski of the University of California, Los Angeles, David Lansky of the Pacific Business Group on Health, Ruth Liu of Kaiser Permanente, Steve McDermott of Hill Physicians Medical Group, Lenny Mendonca of McKinsey & Company, Len Nichols of George Mason University, Sean Randolph of the Bay Area Council Economic Institute, Wade Rose of Catholic Healthcare West, and David Sayen of the Centers for Medicare and Medicaid Services.

Bay Area Council Economic Institute

201 California Street, Suite 1450, San Francisco, CA 94111

(415) 981-7117 • Fax (415) 981-6408

www.bayareaeconomy.org • bacei@bayareacouncil.org

Contents

Executive Summary

California is experiencing a healthcare affordability crisis. Businesses large and small are struggling to pay spiraling healthcare costs. The state government is cutting billions from spending for public healthcare programs that care for children, seniors and the disabled. Families are being forced to make difficult financial choices, and many are going without needed care.

The Affordable Care Act (ACA) created a framework that could be used to ratchet down rising health spending, and dozens of state-based proposals aim to improve healthcare affordability. **What is missing is a strategic vision for an affordable, high-quality healthcare system for California.**

This report is aimed at the state's business leaders who have an essential role in shaping that vision, mapping it out, and creating systems for measuring progress toward our goals. The report provides a roadmap laying out the specific actions by healthcare providers, insurers, businesses, governments, and individuals that will improve affordability and access to high quality care in California.

Achieving affordability will require quickly building on proven California-grown successes in cost control. We must also make the right decisions as we implement federal healthcare reform. One particularly critical task is setting up a successful California Health Benefit Exchange, the new marketplace for purchasing private health insurance.

Since controlling costs while improving quality is our ultimate goal, the solution is meaningful consumer choice among healthcare systems that have both the financial incentive and the technical capabilities to maximize health and wellness.

1. Financially Rewarding High-Value Care

Payers should move to embrace payment models that maximize health while preserving resources.

- California payers should quickly ramp up projects that encourage and reward integrated, high-value care.
- Healthcare purchasers should give preference to projects that deliver savings up front.
- Policymakers should give maximum flexibility to healthcare providers to develop new models to deliver care to the large, newly insured population.

2. Building a Successful Health Benefit Exchange

The California Health Benefit Exchange should be structured as a powerful partner with other payers in promoting delivery system reform.

- The Board of the Exchange should focus on developing an efficient, transparent marketplace that fosters competition on price and quality.
- The Exchange should partner with other payers to align incentives that will drive reform of the medical delivery system.
- The Exchange and the state and federal government should not take actions that would hinder the delivery of high-quality, affordable, integrated care.

3. Focusing on Health Outcomes

All payers should aggressively pursue strategies to optimize effective care to make sure patients, especially those with chronic conditions, get the appropriate care at the appropriate time in the appropriate setting.

- Purchasers and providers must partner to better manage chronic illness through the use of proven personnel strategies and self-management.
- Hospitals in partnership with other providers can reduce healthcare-acquired infections and unnecessary hospital readmissions by scaling successful California pilots in these areas.
- Private and public payers and healthcare systems should pursue strategies to utilize comparative effectiveness research to promote high-quality, appropriate care.

4. Effectively Engaging Consumers

Unleash the power of individuals through access to better information about healthcare and empowering people to make healthier choices about diet and physical activity.

- Businesses and other healthcare purchasers should, when feasible, give employees choices between different healthcare networks competing transparently on price and quality.
- Healthcare purchasers should adopt proven value-based benefit designs.
- Businesses should put in place wellness programs that have shown results.
- Californians must take personal responsibility for maximizing their own health and wellness by making healthier choices enabled by policies that expand access to healthy foods and safe communities.

Introduction

The Causes of Rising Healthcare Costs

If we are interested in holding healthcare cost growth down, we must understand the factors that drive costs up. Issues of healthcare and health policy, though, resist easy answers that spring from any ideological perspective. Some advocates promote greater government control as the solution, but government-run systems around the world are themselves facing major challenges in controlling the growth of healthcare costs, and many have moved in recent years to add more market competition to their systems.[1]

Bringing free market forces to bear is not a panacea either. The buying and selling of healthcare goods and services is unlike a traditional competitive marketplace in most important ways.[2] Above all, the decision of whether to purchase goods and services is often a matter of life and death, not the best time to drive a hard bargain.

In spite of this complexity, it is not only possible but essential to make good business decisions about purchasing healthcare. This process must start with a solid understanding of cost drivers. Here are the three most important things to know about rising healthcare costs:

1. High healthcare costs are the result of the high price of healthcare.

It is widely appreciated that the United States spends vastly more than other developed countries on healthcare and yet Americans have below average health outcomes.[3] **What remains poorly understood is why we pay more.**

A McKinsey Global Institute report[4] is one among many analyses showing that in the United States the answer is not primarily higher administrative costs. These costs account for only 7% of all healthcare spending in our country and explain only 14% of our excess spending as compared to the rest of the world. Nor is the explanation that we receive more services

[1] Organisation for Economic Co-operation and Development. *OECD Health Data 2010* from the OECD Internet subscription database updated October 21, 2010.

[2] See e.g., Len Nichols, et al, 2004, "Are Market Forces Strong Enough To Deliver Efficient Health Care Systems? Confidence Is Waning," *Health Affairs*, 23: 8-21; Christoper Millet, et al, "Unhealthy Competition: Consequences of Health Plan Choice in California Medicaid," *American Journal of Public Health*, 100: 2235-2240.

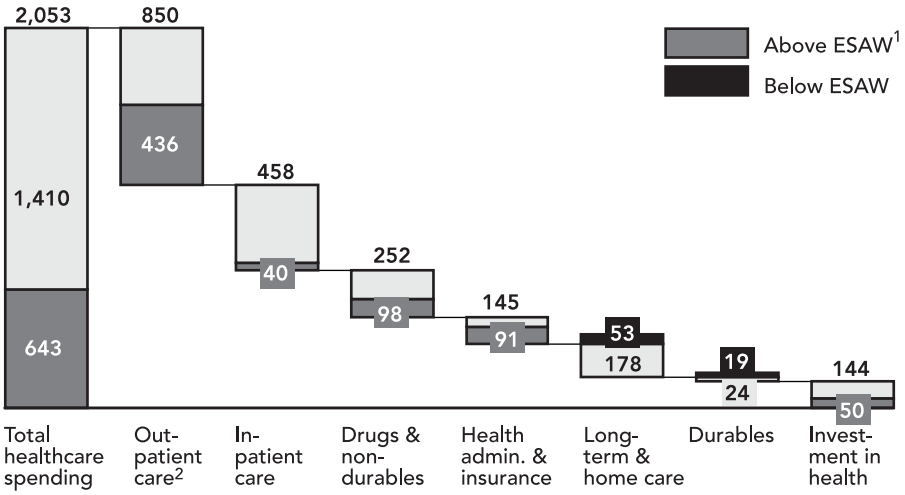
[3] See e.g., K. Davis et al, May 2007, "Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care," *The Commonwealth Fund*.

[4] McKinsey Global Institute, December 2008, "Accounting for the cost of US Healthcare: A new look at why Americans spend more."

than in countries where governments are said to tightly "ration" care. Americans actually have a below average number of primary care physician visits and hospitals days as compared to the rest of the developed world.[5]

U.S. Healthcare Spending
Billions of Dollars, 2006

The United States spends nearly $650 billion more than expected, with outpatient care accounting for over two-thirds of this amount.



[1]McKinsey leveraged health care data collected and compiled by the Organisation for Economic Co-operation and Development (OECD). Using data from 13 OECD peer countries, they developed a measure they call Estimated Spending According to Wealth (ESAW) that adjusts health care spending according to per capita GDP.

[2]Outpatient care includes physician and dentist offices, same-day visits to hospitals including Emergency Departments (ED), ambulatory surgery (ASC) and diagnostic imaging centers and other same-day care facilities.

Source: OECD and McKinsey Global Institute analysis; see McKinsey Global Institute, December 2008, "Accounting for the cost of US health care: A new look at why Americans spend more," p. 14.

Costs are higher in the United States because we *pay* more for healthcare.[6] We pay more for physician visits, hospitals stays, pharmaceuticals, medical devices and most other healthcare services. Both medical specialists *and* primary care physicians in the United States make substantially more than their counterparts around the world even after adjusting for relative national wealth.[7] While chronic disease rates are climbing more quickly

[5] OECD, 2010; MGI analysis, 2008; Americans do receive a greater intensity of services per hospital day, though there is little evidence that this is related to higher prevalence of disease or creates better outcomes.

[6] See e.g., Gerard F. Anderson et al. 2003, "It's The Prices, Stupid: Why The United States Is So Different From Other Countries." *Health Affairs* 22(3): 89-105; Jonathan Oberlander and Joseph White, "Public Attitudes Toward Health Care Spending Aren't The Problem; Prices Are," *Health Affairs* 28: 1285-1293.

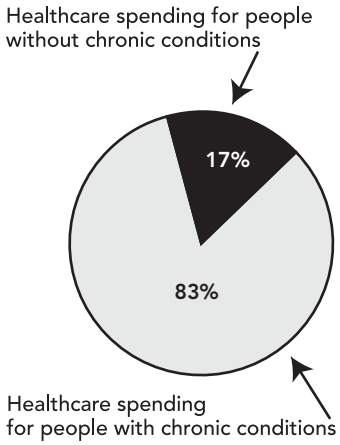
[7] Specialists in the United States earn, on average, 5.7 times per capita GDP, whereas the median for developed countries is 3.3; for primary care physicians ratio in the U.S. is 4.1 whereas the international

among Americans, this does not explain nearly as much of higher healthcare spending as the increased cost of treating illnesses, particularly in the hospital.[8]

Controlling healthcare costs, therefore, will primarily involve paying less over time to some providers for some services and more over time to providers who deliver high-value care consistently. However, this is a project which must be approached with great thoughtfulness. We must proceed in a way that does not cut off access to physicians, destabilize hospital systems, or staunch medical innovation. The best strategy to lower costs without sacrificing quality is the central one recommended by this report: promoting meaningful consumer choice among healthcare systems that have both the financial incentive and the technical capability to maximize health and wellness.[9]

2. Most healthcare spending buys care for chronic conditions.

When we think about healthcare, we generally think about acute conditions: taking a feverish child to the doctor's office or going to the hospital because of a car accident. However, the vast majority of healthcare dollars are not spent on these isolated incidents but on care for ongoing chronic conditions. Specifically, the bulk of spending goes toward care for people with four conditions: coronary artery disease, congestive heart failure, diabetes, and depression. By some measures, care for chronic disease accounts for as much as 83% of all medical spending.[10]



median is 3; U.S. Health Care Spending: Comparison with Other Organizations for Economic Co-operation and Development (OECD) Countries, the Congressional Research Service (CRS), September 17, 2007; see also Miriam J. Laugesen and Sherry A. Glied, "Compared To Other Countries Higher Fees Paid To US Physicians Drive Higher Spending For Physician Services," *Health Affairs*, 30, no.9 (2011):1647-1656

[8] Charles S. Roehrig and David M. Rousseau, 2011, "The Growth In Cost Per Case Explains Far More Of US Health Spending Increases Than Rising Disease Prevalence," *Health Affairs* 30: 1657–1663.

[9] This strategy builds largely on the vision of managed competition laid out by Stanford economist Alain Enthoven, 1978, "Consumer Choice Health Plan: Inflation and Inequity in Health Care Today: Alternatives for Cost Control and an Analysis of Proposals for National Health Insurance," *New England Journal of Medicine* 298:650-658 & 709-720.

[10] George Halvorson, 2007, *Health Care Reform Now!* Jossey-Bass, a John Wiley and Sons imprint; even the very lowest end of the range of estimates show that chronic care accounts for a plurality of medical spending see, Conway, P., et al., 2011, "Patient-Centered Care Categorization of U.S. Health Care Expenditures," *Health Services Research*, 46: 479–490.

There is a relatively small group of people who have these conditions, and they often have more than one. The end result is that roughly 5% of people account for about 50% of medical spending.[11] These are also, disproportionately, people who are in the last year of their lives.[12] So whether we look at the number of conditions, the number of patients, or the number of months that account for the vast majority of medical spending, it is very heavily concentrated among a very few. Therefore, the solutions for reining in high healthcare costs need to focus largely on high-cost populations with chronic conditions.

This report maps out strategies that focus on both the "demand" and "supply" sides of bringing down the cost of caring for people with chronic diseases. On the demand side, it is critical to prevent people from becoming obese—and from developing chronic conditions such as diabetes early in their lives. Although our state's obesity rate does not exceed the national average, fully 30% of adolescents in California are afflicted with obesity, and many of them are also diabetic or pre-diabetic.[13] This is both morally unacceptable and fiscally unsustainable.

On the "supply" side, we have to become markedly more efficient in treating chronic disease using proven strategies that focus on returning people to health and keeping them *out* of the medical system. Again, the solution—and this is particularly true as it relates to chronic disease—is high-performing health systems with the financial incentive and technological capability to manage complex cases and return people to maximal health.[14]

3. California healthcare costs have historically been low but are growing quickly.

California is often cited as having relatively low per capita healthcare costs. This remains true,[15] but it is not primarily a product of lower healthcare prices in the state. Our healthcare costs are lower largely because California has a younger, healthier population than most states. The penetration of managed care systems means that utilization—the volume of healthcare services delivered—is also somewhat lower in California than elsewhere in the nation.

---

[11] Mark Stanton, June 2006, "The High Concentration of U.S. Health Care Expenditures." *Agency for Healthcare Research and Quality*, Research in Action, Issue 19. AHRQ Publication No. 06-0060.

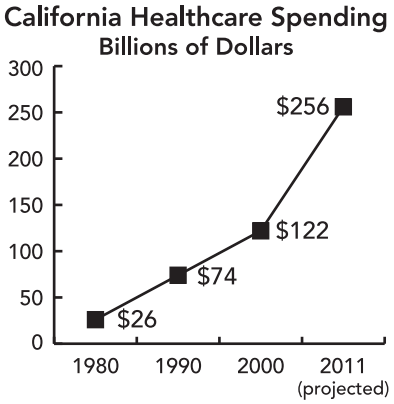
[12] Hoover, Donald R, et al., 2002, "Medical Expenditures during the Last Year of Life: Findings from the 1992–1996 Medicare Current Beneficiary Survey." *Health Services Research 37*(6): 1625-1642.

[13] Child and Adolescent Health Measurement Initiative, 2007, National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Retrieved July 2009 from www.nschdata.org.

[14] Committee on Quality of Health Care in America, Institute of Medicine, 2001, "Crossing the Quality Chasm: A New Health System for the 21st Century," Washington DC: National Academy Press; Chapter 8, Aligning Payment Policies with Quality Improvement.

[15] Congressional Budget Office, based on data from the Centers for Medicare and Medicaid Services.

California is slipping, though, in its relative frugality.[16] Over the last decade or so, California has been moving away from models of managed care that have been effective at keeping healthcare spending growth low—and that the Affordable Care Act (ACA) seeks to promote.[17] One result is that healthcare costs, particularly in California's hospitals, have grown substantially over the course of the past ten years.[18]



The strategies recommended in this report are designed to put the state back on track. They will help relieve the cost pressures that have been reducing the profitability of large businesses, choking the growth of small businesses, discouraging entrepreneurship, and forcing families to choose between medical care and other essential purchases. The time is now for the California business community to take a leading role in getting spiraling healthcare costs under control.

[16] The California HealthCare Foundation, California Health Care Spending, Quick Reference Guide, 2010.

[17] Paul Ginsburg, et al., Dec. 2009, "Shifting Ground: Erosion of the Delegated Model in California," *California HealthCare Foundation*.

[18] Berenson, Robert A., Paul B. Ginsburg, and Nicole Kemper, February 25, 2010, "Unchecked Provider Clout In California Foreshadows Challenges To Health Reform," *Health Affairs*.

Best Practices for Controlling Rising Healthcare Costs

1. Financially Rewarding High-Value Care

Payers should move to embrace payment models that maximize health while preserving resources.

Opportunity: Cost Containment in Federal Reform

The most effective way to control costs for healthcare is to financially reward physicians for providing it. This means rewarding them for maximizing wellness and returning people to health as quickly and efficiently as possible once they fall ill. Unfortunately, in the United States, we still have a system that largely rewards healthcare professionals not for the value of the care they provide but for the volume of services they deliver.

Though conventional wisdom suggests that federal healthcare reform did not include cost containment, the ACA actually includes a broad set of provisions designed to reward high-value integrated care that focuses on maximizing wellness. In fact, nearly two-thirds of its pages are devoted to describing new projects and programs that aim to improve the quality of medical care while lowering its cost.

These cost-controlling elements of federal healthcare reform include:

- "Accountable Care Organizations" and "Patient-Centered Medical Homes";
- Testing and evaluation of new payment models for hospital and physician services in both the Medicare and Medicaid programs, including "bundled payments" and "value-based purchasing" by hospitals;
- A new center that will focus on innovation to promote quality and affordability within public programs;
- A new oversight board that has the power to change the Medicare program to improve quality and slow the rate of cost growth;
- Promotion of patient engagement through shared decision-making;
- Investments in cost-effective community clinics;
- Establishment of a major new program to produce and disseminate comparative effectiveness research; and
- Many programs to improve care for chronic diseases.[19]

[19] See e.g., Meredith Hughes and Alison Levy, April 2010, "The Patient Protection and Affordable Care Act: Delivery System Reform, A Quick Reference to the Major Provisions," *New America Foundation.*

In spite of the political controversy surrounding passage of the law, these are all ideas with bipartisan pedigrees, and the recently introduced Republican budget relied on the savings estimated to be generated by these new initiatives.

California is well-positioned to take advantage of these opportunities due to the state's unique history with high-value integrated healthcare systems. In fact, in many ways California is ahead of the curve. Our state should use the momentum provided by the ACA to expand even further its homegrown systems that provided much of the inspiration for healthcare reform.

Accountable Care Organizations

One of the elements of the federal law that has received the most attention are the Accountable Care Organization (ACO) programs for Medicare. The Medicare Shared Savings Program will allow "participants who work together to manage and coordinate care for a defined population…to receive payments for shared savings if they can reduce spending growth below target amounts."[20] The ACA also includes the "Pioneer ACO program" pilot which allows for more risk-taking and includes payment more closely tied to improving the health outcomes of an entire patient population. Many California-based organizations are expected to participate in these programs.

It is important to differentiate, though, between the ACO programs in the ACA and the general concept of an organization that is both medically and financially accountable for the care of its members. There are many versions of "accountable care organizations," all of which on a basic level are capable of delivering a full range of services for their patients and bear some medical and financial risk for their care.[21] Though they are a foreign concept in many other states, ACOs of one type or another have been up and running in California for many years.[22]

Kaiser Permanente, an alliance between a non-profit health plan and hospital network and a for-profit physician group is an example of an ACO. The California "delegated model" in which insurance companies rely on provider groups such as Independent Practice Associations (IPAs)[23] also

[20] Mark Zezza, April 14, 2011, "Proposed Rules for Accountable Care Organizations Participating in the Medicare Shared Savings Program: What Do They Say?" *The Commonwealth Fund*.

[21] Elliott S. Fisher and Stephen M. Shortell, October 20, 2010, "Accountable Care Organizations," *JAMA: The Journal of the American Medical Association 304*, no. 15: 1715-1716.

[22] Some have suggested that accountable care organizations are simply a new term for HMOs (health management organizations), but there are notable differences. In particular, ACOs are partnerships between payers and providers in which providers take a substantial leadership role whereas HMOs were largely insurer-led. But there are also important similarities and each focus on the effective management of care.

[23] K Grumbach, et al, 1998, "Independent practice association physician groups in California," *Health Affairs*, 17, no.3: 227-237.

delivers "accountable care." The capped or partially capped budget for these providers means that they are responsible for and accountable for the care of each patient. They benefit financially from any efficiencies they create; they are financially disadvantaged to the extent that the care they provide is ineffective or inefficient.

California is also moving toward a greater prevalence of managed care in its public programs. The state negotiated a $10 billion waiver with the federal government in 2010 that has resulted in the ongoing move of its high-cost, vulnerable SPD (seniors and persons with disabilities) population into integrated systems of care that have demonstrated that they have adequate provider networks.[24] This is a vitally important effort, first because it is an attempt to improve care for a population to which we have a moral obligation, and second because the lack of management and coordination of care for this high-cost population has been immensely costly to the state.

Evidence: Incentives are the Key to Affordability

Evidence overwhelmingly supports the proposition that the key to high-quality affordable care is a strong financial incentive for providers to deliver efficient care and keep people healthy and well. Financial incentives help shape the behaviors of healthcare providers and hence bring down costs. The key is paying for value, not volume, which puts the focus squarely on restored health and ongoing wellness, rather than simply on services delivered.

However, it is not enough to simply change the financial incentives for providers without creating an infrastructure of clinical integration and financial management that allows providers to respond to these incentives. This is the motivation behind the ACO projects. You must walk before you can run. In California, however, many groups have been running for years and there is solid evidence that integrated multi-specialty groups are capable of delivering higher quality, more cost-effective care.[25]

One good example of how improving clinical integration and providing incentives for efficiency in care delivery can quickly produce results is the partnership established between Blue Shield of California, Hill Physicians Group and Catholic HealthCare West to improve care for Sacramento-area CalPERS members. The organizations jointly committed to achieve cost reductions that would prevent any increase in premiums in 2010 for the 41,000 CalPERS members enrolled with Hill Physicians. If the cost reductions

[24]A comprehensive online repository of documents related to this waiver can be found at: http://www.dhcs.ca.gov/provgovpart/pages/waiverrenewal.aspx

[25] William B. Weeks et al., May 1, 2010, "Higher Health Care Quality And Bigger Savings Found At Large Multispecialty Medical Groups," *Health Affairs*, 29, no. 5: 991-997.

exceeded the target, the three organizations would share in the savings and if the reductions fell short, the three would bear shared financial responsibility for the shortfall.

Spurred on by these financial incentives, the organizations worked together to improve care coordination and efficiency. As a result of these efforts, unnecessary readmissions to local hospitals were cut by 22% and length of stay and total hospital days were reduced by 12.9%, generating an estimated $15.5 million in savings for CalPERS. Blue Shield of California and five major healthcare providers subsequently announced two new accountable care initiatives designed to provide integrated, cost-efficient healthcare to 26,000 employees, dependents, and retirees who are HMO members of the San Francisco Health Service System (HSS). Blue Shield is partnering with Brown & Toland Physicians Group and California Pacific Medical Center (a Sutter Health affiliate) for the integrated care of 21,000 HSS members assigned to Brown & Toland physicians, and with Hill Physicians Medical Group, Catholic Healthcare West, and the University of California, San Francisco for the care of 5,000 HSS members assigned to Hill physicians. As a result of these collaborations, premiums for San Francisco HSS members will be kept level for 2011–2012.

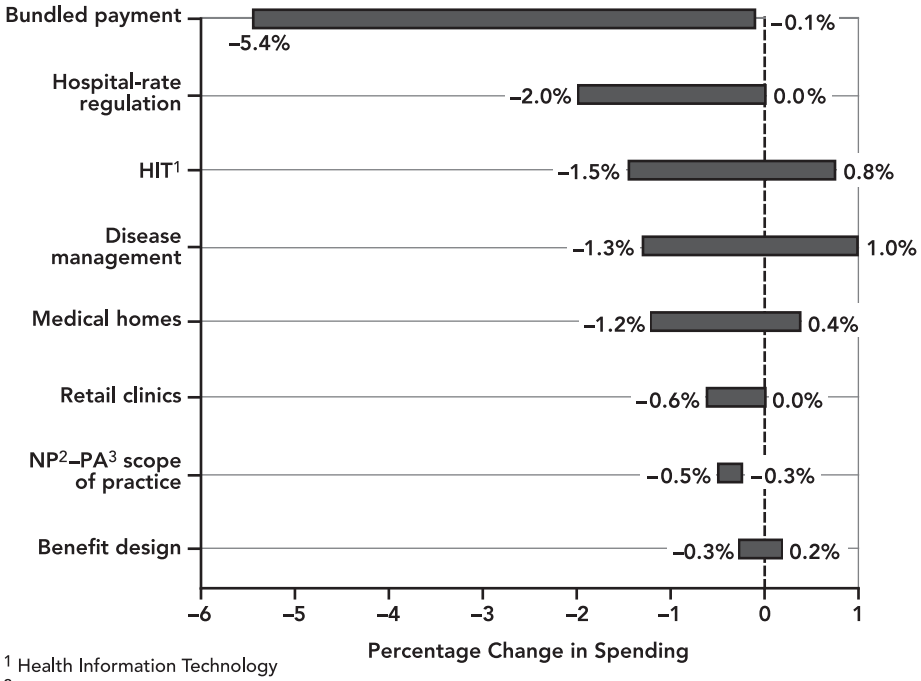
Just as there is a continuum of different types of integration, there is also a broad range of different payment types that align incentives toward the promotion of better health outcomes and more efficient care. A significant subset of healthcare provider groups in California is "fully capitated," meaning that they receive a fixed amount for each patient's care. But aligning incentives does not require full capitation. There are many examples of these kinds of payments, one of which is a bundled payment approach. With a bundled payment, a single payment is given to a network of providers for all of the care associated with a particular service, such as knee replacement. The providers then have to work together to make the entire procedure and rehabilitation process go as smoothly as possible. If they do, they share in the savings produced through this process.

The RAND Corporation did an extensive evaluation of the promise of a number of different cost controlling strategies, and this type of bundled payment emerged as by far the most promising compared to disease management or investments in health information technology.[26] Bundled payment is just one example of a strategy that realigns incentives to tie financial reward to positive outcomes.

[26] RAND Corp., December 2009, *Controlling U.S. Healthcare Spending— Separating Promising From Unpromising Approaches.*

Options Offering the Potential to Reduce Healthcare Spending

Estimated Cumulative Percentage Changes in National Healthcare Expenditures, 2010 through 2019, Given Implementation of Possible Approaches to Spending Reform



[1] Health Information Technology
[2] Nurse Practitioner
[3] Physician Assistant
Source: RAND Corp. analysis; see RAND Corp, December 2009, "Controlling U.S. Health Care Spending – Separating Promising from Unpromising Approaches."

The Integrated Healthcare Association, a California-based group made up of leaders from physician groups, hospitals, and health plans, has been doing pioneering work in this and many other areas,[27] building on their track record of fostering successful collaboration among stakeholders in their widely recognized Pay-for-Performance program. This program is now being adapted to include measures of cost, value, and efficiency as well as medical quality.

The key to promoting affordability is figuring out which correctly aligned payment systems providers are best positioned to adopt, and then moving quickly to adopt these new payment models. The effectiveness of these payments is directly correlated to their size, however: the greater the percentage of providers' incomes at stake, the greater the behavioral

[27] James C. Robinson and Kimberly MacPherson, September 2011, "Aligning Consumer Cost-Sharing with Episode of Care (EOC) Provider Payments," Integrated Healthcare Association; James C. Robinson, Thomas Williams, Dolores Yanagihara, September 2009, Measurement Of And Reward For Efficiency in California's Pay for Performance Program, *Health Affairs*, 28(5): 1438-1447.

change. Programs that are oriented around bonuses, such as the pay-for-performance programs pioneered in California,[28] can make substantial contributions in terms of standardizing measures and promoting clinical integration, but they alone will not move the needle enough to resolve the affordability crisis.

Actions

To build on California successes in promoting affordability and improving quality:

- *Move toward accountable care.*
  Payers should quickly ramp up projects that encourage and reward integrated, high-value care. This includes private initiatives such as virtual integrated delivery system pilots and state actions through the Medicaid program. The move toward accountable care will require active participation in federal projects such as the Medicare Shared Savings ACO program.

- *Create consistent signals across providers.*
  When California insurers embed financial incentives into their products to promote affordability and when public programs structure their reimbursement strategies to promote integration, it is critical that these incentives work together. Too often they are in conflict. The California Health Benefit Exchange, as the portal to coverage through both public and private programs, should help to coordinate these incentives across payers.

- *Give preference to up front savings.*
  In order to achieve affordability by 2014, preference should be given to projects that can deliver a lower price point on the front end instead of simply promising savings on the back end. This includes delivery system reform pilots that keep premium increases stable and the development of high-value networks. A good example is the virtual integrated delivery system that was developed for the California Public Employees Retirement System which guaranteed a zero percent premium increase in its pilot year.

- *Remove regulatory barriers to efficiency.*
  Under ACA we will be moving millions of Californians into existing systems without substantially increasing the capacity of these networks or the number of providers in them. This means that these networks will have to use all of the tools at their disposal to serve their patients.

[28] Meredith B. Rosenthal and R. Adams Dudley, February 21, 2007, "Pay-for-Performance," *JAMA: The Journal of the American Medical Association,* 297, no. 7: 740 -744.

Though California has been a very progressive state in terms of its innovations around integrated, accountable care, it still has some of the most conservative regulations governing how that care is delivered. Financial incentives to provide efficient care will only be successful to the extent that doctors, hospitals and other providers of healthcare can flexibly adapt to respond to these incentives.

2. Building a Successful Health Benefit Exchange

The California Health Benefit Exchange should be structured as a powerful partner with other payers in promoting delivery system reform.

Opportunity: Exchanges in the ACA and California

The ACA creates new state-based health insurance marketplaces called "health benefit exchanges." Starting in 2014, approximately 4.5 million Californians will be eligible for subsidies to purchase private health insurance coverage policies through these new markets.[29] The exchanges will also be a portal where people will learn of their eligibility for public programs. Health insurance will still be sold outside of the exchange, but to receive the new federal subsidies created by the ACA, people must purchase insurance through this new marketplace.

In September 2010, California passed legislation that created the California Health Benefit Exchange. It was the first such market to be set up directly in response to federal reform. In April 2011, the board of this independent state agency began meeting regularly, hiring staff, and moving quickly toward the development of this central component of federal healthcare reform.

The agency will oversee two purchasing pools, one for individuals and one for small groups. Individuals will receive substantial subsidies that will limit the amount they pay in premiums and out-of-pocket expenses. The Small Business Health Options Program (or "SHOP exchange"), is anticipated to be open to groups with 2–50 employees from 2014 to 2016 and to groups with up to 100 employees after 2016.[30] Small businesses will receive tax credits that reduce the cost of purchasing health insurance, but these credits will last for only two years.

The state also has the choice to open this exchange to businesses over 100 employees after 2017. Therefore, if designed and administered correctly,

[29] Mercer, May 2011, "Exploring the Financial Feasibility of a Basic Health Program in California," *California HealthCare Foundation*.

[30] The state has the option to open the pool to groups with 51-100 employees in 2014 but is not currently expected to do so. The self-employed may be allowed to purchase insurance through the SHOP Exchange.

the Exchange could over time become an important solution for both large and small employers. However, the state will have to carefully evaluate when and how to open the Exchange to large employers in order to avoid adverse selection. Since this marketplace is community-rated, it could be a more attractive option for businesses with higher than average health risk. It is important to attract and maintain a stable risk pool for exchanges if they are to be successful.

Even in its initial phases, though, the operations of the Exchange will be relevant to the broader California business community. It has the opportunity to coordinate with other major purchasers of healthcare including large businesses and other government programs. They can work together, in particular, to create consistent financial incentives—such as those discussed in the preceding section—for healthcare providers to help make the healthcare delivery system more efficient and effective.

California has selected an "active purchaser" model for its exchange. This means that instead of the Exchange simply being a portal where people can learn about their health insurance options, its board will have a broad range of tools available to bargain for better prices on behalf of its enrollees and to work with its insurer partners to create innovative products that enhance affordability and improve quality.

Evidence: Exchanges Can Drive Delivery System Reform

The exchanges included in the ACA are modeled on a number of different purchasing pools, which range from the Federal Employees Health Benefit Program that serves 8 million people nationwide to PacAdvantage, the defunct small business exchange that served a niche market of small businesses in California. The regulations put in place to govern the insurance market—both in and outside of the exchange—were crafted to address some of the issues that have limited the effectiveness or compromised the viability of exchanges in the past.

Exchanges that are voluntary and unsubsidized, such as PacAdvantage, have generally not driven down health insurance rates[31] and have had difficulty becoming self-sustaining over the long term. PacAdvantage was the victim of adverse selection—meaning that it developed an unhealthy risk pool that was prohibitively expensive to insure—and it had to be shut down.[32] Adverse selection is a major issue for all insurers and purchasing

[31] Among the factors that drive costs up in small business purchasing pools are group instability and risk selection. See Rick Curtis and Ed Neuschler, May 2009, "What Health Insurance Exchanges or Choice Pools Can and Can't Do About Risks and Costs," *Institute for Health Policy Solutions*; Peter Lee and John Grgurina, August 12, 2009, "What People Don't Know About Health Insurance Exchanges," *Health Affairs*.

[32] Micah Weinberg and William Kramer, "Designing Successful SHOP Exchanges: Lessons from California's Experience," Pacific Business *Group on Health*, June 2011.

pools. Federal reform took a series of steps to reduce the impact of this dynamic, including the creation of a system of risk adjustment in which insurers with healthier enrollees will make payments to those with less healthy enrollees. However, selection will remain a difficult issue that must be carefully addressed by those designing exchanges.[33]

Many small group exchanges have managed to avoid an adverse selection death spiral and survive based on their main value proposition: allowing small groups to offer employee choice in which employees select the plan that best fits their individual needs. However, since the tradeoff for this increased choice has tended to be slightly higher prices, these exchanges have catered to niche markets. The most successful has been the Connecticut Business and Industry Association's purchasing pool, a private exchange. At its peak, this pool attracted about 10% of the businesses in its state. It is more common for exchanges, such as those run in states such as Massachusetts and California, to attract the business of less than 2% of small groups in the state. The ACA, however, includes provisions that may reduce the adverse selection dynamics within the SHOP exchange and hence make it a more price-competitive and attractive option. These include the law's requirement that all employees choose insurance products that have the same actuarial value.

The small market share of recent small business exchanges suggest that those charged with developing exchanges must be modest about what they can accomplish in the initial phases, particularly as it relates to the SHOP exchange. In federal reform, the key selling points for exchanges were that they would bring down prices and create administrative efficiencies. Federal law now prohibits insurers from offering higher prices for the same products if they are sold through an exchange, an issue that has bedeviled exchanges in the past. But it may not be possible, or even permissible, for these exchanges to offer lower prices uniquely for their enrollees, and exchanges are not intrinsically more administratively efficient.[34]

Building successful insurance exchanges

The individual exchange in federal reform most closely resembles subsidized exchanges such as the state employee exchange in California (CalPERS), or the *de facto* exchanges of large employers such as Stanford and the University of California that provide a range of choices for their employees. These exchanges enhance affordability by providing health insurance shoppers meaningful "apples-to-apples" comparisons among

[33] Timothy Jost, September 2010, "Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues," *The Commonwealth Fund.*

[34] Rick Curtis and Ed Neuschler, "Small-Employer ("SHOP") Exchange Issues, *California HealthCare Foundation*, March 2011.

plans.[35] They can also deliver significant, relatively steady enrollment to the health insurers with which they partner which can, in turn, help drive delivery system reform. The "virtually integrated delivery system" partnership, discussed in the previous section, came about in large part because public employees in California purchase their insurance through a type of exchange where they have a variety of coverage options and insurers have big incentives to innovate ways to contain costs.

The more consumers there are in the Exchange market, the larger the chance we have to fulfill the promise of healthcare reform. If consumers spend very little time in this market because they're busy bouncing around from program to program, they will be less informed about their choices and less able to work together to drive down costs. More informed consumers, on the other hand, give the market mechanism of exchanges the chance to work to produce real cost control.

The issue, therefore, is not simply the sheer number of people in the Exchange (if so, it would be nearly impossible for exchanges to work in states like Nebraska) but rather the percentage of people in a given market that fall into the Exchange and the amount of time that they can be expected to spend in that income range. And to the extent that the Exchange is a large, robust, more standardized and centralized marketplace with affordable options, it will be more appealing to unsubsidized consumers as well.

Actions: Driving Affordability through Meaningful Consumer Choice

The federal legislation offers a great deal of leeway to the states as they design their own exchanges. California's legislation, in turn, leaves a great deal of flexibility to its Exchange board and staff as they set up this new marketplace. This board has the ability to make decisions that enhance the quality and affordability of the products offered. Conversely, their decisions as well as future actions of the legislature could easily exacerbate the affordability crisis.

Provisions of the federal law limit the percent of income that enrollees will have to pay for premiums and out-of-pocket spending. There is no free lunch, though, as higher subsidies will result in higher federal taxes. A recent study by Mercer that examined in great detail the drivers of rising health insurance rates in California estimated that the cost of the subsidies might be roughly 30% higher than has been projected by the Congressional Budget Office.[36] It is impossible to know what the actual cost of health

[35] A. Enthoven and R. Kronick, "A Consumer-Choice Health Plan for the 1990s," 1989, *New England Journal of Medicine,* 320:29–37.

[36] Mercer, May 2011, "Exploring the Financial Feasibility of a Basic Health Program in California," *California HealthCare Foundation*.

insurance will be in 2014, but this study underscores the urgent need to make affordability the chief priority of the Exchange.

The following actions by the Exchange board and staff should enhance the affordability of products offered through this new marketplace:

- *Make choices clear and meaningful.*
  The Exchange board will be responsible for certifying insurance products as "Qualified Health Plans." There is a balance to strike between creating a high standard and layering so many requirements on plans that they become unaffordable. Successful exchanges in the past have unleashed cost-conscious consumer choice by creating apples-to-apples comparisons among meaningful coverage options. This should be the focus of the California Exchange.

- *Partner with high-value integrated networks.*
  The board should use its purchasing power to get the best deal on behalf of its enrollees. But, particularly if the board sharply limits the choices available through the Exchange, participating insurers will have a strong incentive to present unsustainably low initial bids to increase their share of the business sold through this marketplace. They will then have to increase their rates significantly in subsequent years. The most effective strategy to achieve immediate term affordability without driving up healthcare costs over the long-term, therefore, is for the Exchange to offer its enrollees many high-value system choices.

- *Do not prevent the development of integrated networks.*
  A provision in the ACA requires that all Qualified Health Plans include "Essential Community Providers" that provide services to low-income and diverse communities in their networks. These regulations, as refined and promulgated by the federal government and California, should focus on bringing service to these "safety net" communities that adheres to a high and consistent standard. All providers should be encouraged to develop partnerships that will offer a comprehensive range of services. Community clinics and other community-based providers have the ability to connect with and effectively serve diverse populations and have highly developed specialties in areas such as behavioral health. Therefore, they will often be "providers of choice," as well as vital parts of integrated delivery systems that are held accountable for maximizing the health outcomes of large populations over time.

- *Move with the market.*
  The subsidies available through the individual insurance exchanges will not be a complete antidote to adverse selection. Therefore, the Exchange should not develop practices or policies that are distinct from those of the outside market. That is a recipe for adverse selection

which will make it impossible for the Exchange to fulfill its public purpose. It is critical for the Exchange to move in concert with other insurers and payers to make changes in the broader market such as creating a sustainable compensation structure for health insurance brokers and improving consumer protections.

3. Focusing on Health Outcomes

Payers should aggressively pursue strategies to reduce duplicative, unnecessary or harmful medical services, particularly in the care of the chronically ill.

Opportunity: Managing Chronic Disease and Reducing Its Prevalence

In spite of the fact that the majority of healthcare costs are attributable to chronic disease,[37] the United States still has a system that is largely focused on performing procedures such as hip replacements, bypass surgeries, chemotherapy, and CT scans. Recently, healthcare providers, in partnership with businesses and governments, have attempted to move away from a system that rewards volume of procedures toward one that focuses on keeping people well.

It is crucial to continue this transformation, which has many elements including:

- Effectively managing chronic disease by putting in place systems that rely heavily on self-management and the use of allied health professionals;
- Reducing wasteful medical expenditures tied to healthcare-acquired infections which may be dramatically higher than formerly estimated;[38]
- Avoiding unnecessary hospital readmissions, now a financial imperative for hospitals due to a provision of the ACA;
- Utilizing only treatments that have proven to be more effective, and cost-effective, than those currently in place; and
- Integrating palliative care and end-of-life planning into protocols of all healthcare systems.

This is a long list of priorities, but they all share one commonality: they are far easier to implement within integrated systems of care that have the correct financial incentives. The hard truth is that even projects that have been conclusively demonstrated to improve health outcomes are unlikely

[37] George Halvorson, 2007, *Health Care Reform Now!* Jossey-Bass, a John Wiley and Sons imprint.

[38] David C. Classen et al., 2011, "'Global Trigger Tool' Shows That Adverse Events In Hospitals May Be Ten Times Greater Than Previously Measured," *Health Affairs*, 30, no.4:581-589.

to continue if they cause a significant financial drain on healthcare providers or payers.

An excellent example is the treatment of asthma. We have the knowledge and technology to effectively manage this disease and prevent the vast majority of asthma attacks and asthma-related hospitalizations. Yet unmanaged asthma remains surprisingly common in the United States and is responsible for 4,000 deaths each year. Some of this is attributable to poor decisions by individuals, but there are also striking differences in the extent to which asthma is managed by delivery systems with different financial incentives. Systems that benefit financially from keeping patients well and out of the hospital have had excellent results in managing asthma.[39] Conversely, successful asthma management programs at hospitals with the financial imperative to keep all of their beds occupied have been axed after they successfully reduced asthma attacks that required hospitalization. Two doctors responsible for care of children with asthma stress the importance of payment mechanisms in the treatment of this disease and conclude that "Without support from the insurance industry, governments and private foundations, there's no way to convince a hospital administrator that severely reducing the volume of asthma patients that visit each year will be good for the bottom line."[40]

Dr. Atul Gawande has touted the efforts of the "Hot Spotters," medical professionals and researchers that focus on providing more efficient, effective care to the highest utilizers of healthcare, those who are responsible for the vast majority of costs in the system. Their innovations include the use of dedicated healthcare assistants and specialized clinics. Emerging models demonstrate that intensive primary care support and care coordination for the population with multiple chronic conditions can reduce unnecessary medical services and create savings of care of up to 20% in total cost. It is no coincidence that the "Hot Spotters" who operate within systems that have the financial incentive to improve people's health (and hence reduce the medical care they need) have expanded their initiatives. Those who operate within systems that have the financial incentive to maximize the volume of healthcare services delivered rather than to become more efficient, have struggled to maintain their projects in spite of being able to demonstrate improved patient outcomes.[41]

Here in California, the Pacific Business Group on Health's (PBGH) Ambulatory Intensive Care Unit (AICU) project targets high risk, high cost patients, where savings from coordination of care are expected to be significant.

---

[40] Dennis Keefe and David Link, May 14, 2010, "Distorted Financial Incentives Allow Asthma Cases To Increase," *Commonhealth.org*.

[41] Atul Gawande, January 2011, "The Hot Spotters," *The New Yorker*.

Medical groups in this pilot will be compensated with traditional fee-for-service payments, care management fees and shared savings. The pilot will focus on approximately 2,000 patients who reside in the LA/Orange County and Humboldt areas and are employed through CalPERS, Boeing and other PBGH members. The pilots launch in 2011 and continue for two years.

Evidence

Chronic Disease Management

A series of recently-completed Medicare disease management pilots suggests caution but also presents best practices that may better translate into cost-savings outside of this program.[42] One of the main findings of these pilot programs is that self-management and the use of allied health professionals can substantially reduce the cost of preventing and treating these conditions without lowering the quality of care people receive. In fact, community health workers such as *promotoras* in California are often more effective in communicating with people because they have highly developed cultural competencies that traditional provider organizations sometimes lack.[43] Blue Shield of California has pioneered a patient-centered chronic disease management program that produced high satisfaction rates among patients (92 percent) and reduced costs by more than $18,000 per patient, primarily by shifting care from acute, inpatient facilities to homes and hospices.[44]

Healthcare-Acquired Infections

Recent studies show adverse health events might be as much as ten times higher than previously estimated.[45] Adverse events include infections acquired at hospitals such as sepsis and staph infections. Vastly reducing the number of these infections requires no miraculous advances in medical technology. In fact, the most effective techniques are the simplest ones. They include hand-washing and the use of checklists during complicated procedures. These simple techniques can greatly reduce prevalence of healthcare-acquired infections. A widely lauded initiative in this area was

[42] David M. Bott, et al., 2009, "Disease Management For Chronically Ill Beneficiaries In Traditional Medicare," *Health Affairs*, 28, no.1: 86-98; see also Jerry L. Cromwell, Debra A. Dayhoff, and Armen H. Thoumaian, Fall 1997, "Cost Savings and Physician Responses to Global Bundled Payments for Medicare Heart Bypass Surgery,'" *Healthcare Financing Review* 19, no. 1: 41–57; see also M.E. Wynn, Summer 2001, "Modernizing the Medicare Program Using Global Payment Policies," *Managed Care Quarterly* 9, no. 3: 42–51.

[43] Tom Bodenheimer and Sharone Abramowitz, December 2010, "Helping Patients Help Themselves: How to Implement Self-Management Support," *California HealthCare Foundation*. [Featuring Project Dulce in San Diego, a community health worker (*promotora*) model.]

[44] Susan Baird Kanaan, September 2009, "Homeward Bound: Nine Patient-Centered Programs Cut Readmission," *California HealthCare Foundation*.

[45] David C. Classen et al, 2011, "'Global Trigger Tool' Shows That Adverse Events In Hospitals May Be Ten Times Greater Than Previously Measured,'" *Health Affairs*, 30, no.4: 581-589.

the Michigan Keystone project in which checklists dramatically improved the safety of everything from drawing blood to the complicated care required in intensive care units.[46]

The ACA includes a major provision designed to reduce healthcare-acquired infections. Starting in 2015, hospitals that are in the top quartile for the rate for healthcare-acquired infections as compared to the national average will have their Medicare payments reduced by one percent. In subsequent years, these penalties will rise to as much as 3 percent. This provision is crucial to help create a financial incentive for hospitals to reduce the number of infections acquired in their facilities.

There have been several California-based projects to reduce health-care acquired infections that have had great success and are models for the rest of the state and nation. In 2008, Blue Shield of California Foundation launched CHAIPI II in partnership with 51 nonprofit healthcare facilities in California. The foundation expects that this program will avoid as much as $25 million in costs for hospitals, patients, and the healthcare system. Catholic Healthcare West (CHW) launched the three-year initiative in July 2007 with the goal of reducing its inpatient severe sepsis mortality rate by 5% across its 41 hospitals in California, Arizona, and Nevada by 2010. CHW estimates that it has saved 991 lives and reduced the severe sepsis inpatient mortality rate by 33% at the end of three years.

Reducing Unnecessary Hospital Readmissions

Unnecessary hospital readmissions are both extraordinarily costly and demoralizing to the patient. They are too often caused by relatively simple things such as lack of communication with healthcare providers outside of the hospital setting who are responsible for a patient's care or lack of good instructions being given to patients upon discharge. [47] Patients also have a critical role in preventing readmissions by adhering to the instructions and drug regimens that they are given. Working together to vastly reduce the number of unnecessary hospital readmissions may make it

[46] Peter Pronovost et al., 2006, "An intervention to decrease catheter-related bloodstream infections in the ICU,"*New England Journal of Medicine*, 355: 2725–32.

[47] See e.g., The Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, "Educating Patients Before They Leave the Hospital Reduces Readmissions, Emergency Department Visits and Saves Money," February 2009; Brian W. Jack, et al., February 3, 2009, "A Reengineered Hospital Discharge Program to Decrease Rehospitalization," *Annals of Internal Medicine* 150, no. 3: 178-187; Eric Coleman et al., 2006, "The Care Transitions Intervention: Results of a Randomized Controlled Trial," *Archives of Internal Medicine* 166, no. 17: 1,822-8; Naylor, et al., 1999, "Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders: a Randomized Clinical Trial," *JAMA: The Journal of the American Medical Association* 281: 613-20; C Anderson, et al., "Benefits of Comprehensive Inpatient Education and Discharge Planning Combined With Outpatient Support in Elderly Patients With Congestive Heart Failure," *Congestive Heart Failure* 11, no. 6 (November-December 2005) :315-21.

possible to save Californians as much as $16 billion over the course of the next ten years.[48]

This is an extraordinarily important issue, particularly for the high-cost "dual eligible" population, individuals entitled to both Medicare and Medicaid. Too many dual eligibles are moving in and out of hospitals on a regular basis to receive treatment for poorly managed chronic conditions. We all have a strong financial and moral obligation to address this issue.

There are major provisions within the ACA aimed at reducing unnecessary hospital readmissions. To address what are referred to as "excess readmissions," the payment rates from Medicare to hospitals will be reduced if actual readmissions are higher than expected. These payment reductions start at one percent in 2013 and rise to three percent by 2015.

Catholic Healthcare West is among the hospital systems taking the lead on reducing unnecessary readmissions with actions strongly incentivized through federal reform. Their Congestive Heart Action Management Program (CHAMP) is a comprehensive program designed to provide case management and telephonic assistance for patients with CHF. Operating for a number of years in a capitated environment, CHW is further scaling the program to other service areas given the proven impact on reductions in readmissions in keeping with one of the core tenets of healthcare reform. CHAMP has been successful in reducing readmissions in enrolled populations to the single digits and will be partnering with CHW and MercyCare on potential mobile, wireless, and sensor-based care management systems to further reduce likelihood of readmission.

Comparative Effectiveness

One of the major initiatives in the ACA was the creation of the Patient Centered Outcomes Research Institute (PCORI), a new research institution that will evaluate the relative effectiveness of different drugs, devices, and procedures. The most common standard for evaluating new medical treatments is to compare them against a lack of treatment for a condition; in the case of pharmaceuticals, this is generally a placebo. There is a great deal of existing research into the comparative effectiveness of treatments that must make its way more fully into our payment policies and medical practices.

Integrated systems do an excellent job of putting this information at the fingertips of their physicians. The outcome is better care and ultimately better health for patients. One example is the experience of Kaiser Permanente with the drug Avandia, a top-selling diabetes pill that had very dangerous

[48] Micah Weinberg and Leif Wellington Haase, The California Task Force on Affordable Care (Washington, D.C.: *The New America Foundation*, May 2010).

cardiovascular side effects. Though the information on its drawbacks was often effectively concealed from both physicians and consumers, doctors in the Permanente Medical Group had ready access to it through their system's extensive dissemination and use of comparative effectiveness data. Physicians in this group practice are permitted to prescribe any drug that is freely available on the market. However, once Avandia was pulled off the market, it was found that the rate of prescribing it within the Kaiser system was extraordinarily low already.[49] This is an example of good comparative effectiveness data at work.

The use of comparative effectiveness data itself can be relatively controversial. Some are concerned that it will make it more difficult to access new experimental treatments. Another set of concerns arises when cost information is added to comparative effectiveness studies. In these cases—and there is a vast amount of research both in the United States and internationally that uses these methods—medical treatments are evaluated not only for the number of Quality Adjusted Life Years (QALYs) that they extend life but also for the cost of each year of additional life. Amassing such information and using it to make decisions about coverage either through public programs or private insurance, is often deemed "rationing."

However, the spiraling cost of medical care in the country means that in the United States, we effectively ration based on ability to pay. This is not simply because there are millions of Americans who cannot afford any insurance. It also impacts people who are privately insured. Because comparative effectiveness, including the cost of services, is not adequately incorporated into the decision-making of payers, insurance is often required to pay for expensive treatments for a very few—treatments that may extend life for only a short period of time but at enormous cost. The result is that insurance policies have higher copayments and premiums than they would otherwise, and they often do not have the full scope of preventative and basic services necessary to maintain people's health. Federal healthcare reform requires that preventative services be included in most healthcare policies without a copayment. However, no services are provided free of charge. To the extent that we do not use the best information about the effectiveness and price of medical treatments, costs will be driven up for everyone.

Unnecessary or Harmful Care

Imaging, including the use of MRI and CT scans, is a prime example of an area where better practices must be developed to ensure that care actually improves patient outcomes. Diagnostic imaging has been one of the fastest growing medical expenditures in the U.S. for both public and private payers over the past two decades. While much of this growth can be

[49] Sharon Levine, Campaign for Comparative Effectiveness event, 2010.

attributed to improving technology and factors such as the rapidly aging population, as much as one-third of all outpatient imaging is clinically unnecessary. Further, some unnecessary or clinically-inappropriate imaging that emits radiation is harmful to patients due to the long-term effects of radiation exposure and the additional unnecessary "down-stream" clinical procedures driven by false positives.

American Imaging Management (AIM), which is affiliated with Anthem Blue Cross of California, has achieved some success in promoting improved clinical appropriateness, patient safety and affordability within the outpatient healthcare services sector. The goal of AIM is to increase quality and reduce costs by actively educating ordering physicians (at the time of decision-making) on the most appropriate clinical guidelines and protocols. Its work to date has helped maintain a relatively flat growth rate for outpatient imaging over the last five years and has prevented thousands of costly, clinically unnecessary, and potentially dangerous services for patients.

Palliative Care and End-of-Life Planning

Improving quality in caring for people at the end of their lives is a particularly promising strategy for reducing healthcare costs in the short-run, and some very solid evidence has emerged on demonstrated best practices in this area. Fortunately, this evidence indicates that end-of-life planning can extend people's lives as well as preserve the financial resources of their families and bring down total healthcare costs for the system. Unfortunately, this issue that generally difficult to discuss and is ripe for misrepresentation.

End-of-life care is responsible for a significant proportion of healthcare spending.[50] It has been shown that good palliative care, including the use of pain management and hospice, can produce savings for all payers. In this, as in all other areas, proper planning is paramount. All payers, when feasible, should encourage use of POLST (Physician Orders for Life-Sustaining Treatments),[51] a very detailed type of living will that ensures that the patient's wishes are respected with regard to their end of life treatment.

One example of an inpatient palliative care program, developed in Kaiser Permanente's Colorado region, is built around specially trained care teams, each consisting of a physician, a nurse, a social worker and a spiritual adviser. These hospital-based teams consulted regularly with all adult patients who have been referred for palliative care, as well as with family members. Based

[50] Mark Stanton, June 2006, "The High Concentration of U.S. Health Care Expenditures." Agency for Healthcare Research and Quality, *Research in Action*, Issue 19. AHRQ Publication No. 06-0060.

[51] Jennifer S. Temel, 2010, "Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer," *New England Journal of Medicine*, 363: 733-42; R. Sean Morrison et al., 2011, "Palliative Care Consultation Teams Cut Hospital Costs For Medicaid Beneficiaries," *Health Affairs*, 30, no.3: 454-463; Kathy Glasmire and Kathleen Kerr, March 2011, "Be Prepared: Reducing Nursing Home Transfers Near the End of Life," *California HealthCare Foundation*.

on each individual patient's goals, the team assesses and discusses options for pain and symptom management psychological and spiritual support, end-of-life planning, and outpatient care following the hospitalization.

A two-year randomized control trial of the program[52] found that the patient group that received palliative services reported greater satisfaction with their hospital care experience, better communications with providers, and better spiritual support. They also completed more advanced directives than the control group, and they had significantly fewer intensive care admissions and lower hospital costs as well as lower total health services costs. This translated to an average total cost savings of approximately $12,000 per enrolled patient. This program has been adopted throughout Kaiser Permanente's facilities in the state of California.

Actions

The focus of private and public payers in California should be on partnering with efficient integrated delivery systems that will compete for price-conscious consumers. These systems are the best suited to develop and deploy techniques to eliminate harmful and duplicative services, since integrated delivery models generally have the right set of financial incentives and practice team-based care. The following set of specific actions will also control costs while improving the quality of medical care delivered in the state.

- *Employ effective chronic disease management techniques.* Purchasers and providers must partner to better manage chronic illness through the use of proven personnel strategies and financial incentives. With the support of healthcare professionals, Californians with chronic diseases must also take an active role in their own care. In this as in other areas, healthcare costs can only be controlled through people taking personal responsibility by adhering to the instructions that they are given by their providers and taking actions necessary to maximize their own wellness.

- *Scale successful healthcare-acquired infection pilots at California hospitals.* Hospitals in partnership with other providers can reduce healthcare-acquired infections and unnecessary hospital readmissions by scaling successful California pilots in these areas. Private payers should follow the lead of Medicare by creating incentives for hospitals to invest time and energy into eliminating all preventable diseases through simple techniques such as handwashing and the use of checklists, as well as

[52] Glenn Gade et al, March 2008, "Impact of an Inpatient Palliative Care Team: A Randomized Controlled Trial," *Journal of Palliative Medicine*, 11(2): 180-190.

more extensive process redesign at hospitals, clinics and other healthcare facilities.

- *Insist on the usage of comparative effectiveness data with cost information.* Private and public payers and healthcare systems should pursue strategies to utilize comparative effectiveness research that includes cost. The affordability crisis is too acute to avoid using the best scientific research on the relative effectiveness of drugs, devices and procedures. A critical part of getting value for medical spending is utilizing data not only about whether a particular medical intervention will have a superior result as compared to other alternatives, but also about what the relative cost of each intervention is.

- *Engage Californians with end-of-life care issues.* Providers must integrate palliative care and end-of-life planning into their protocols with the support of healthcare purchasers and the public. The patient and the patient's family must be at the center of these decisions. This will require extensive education of the general public about how palliative care can not only vastly improve a person's quality of life but can often also extend life.

4. Effectively Engaging Consumers

Unleash the power of individuals through access to better information about healthcare and empowering people to make healthier choices about diet and physical activity.

Opportunity: Consumer Engagement

Giving healthcare consumers a financial stake in the decisions they make, both when purchasing health insurance and when paying for healthcare, can reduce medical spending without having significant deleterious effects on health.[53] These choices, however, must be structured carefully.

Federal healthcare reform not only expands healthcare coverage, it also increases the engagement of consumers with the cost of their own care. The central vehicle for the expansion of private coverage through the ACA is the "health benefit exchange," (described in greater detail on page 14). The products sold through health benefit exchanges will have cost-sharing that will vary by income level but that will generally be greater than the cost-sharing typically available through traditional employer-sponsored

[53] Robert H. Brook et al, December 1984, "The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment." Santa Monica, Calif.: RAND Corporation, R-3055-HHS.

healthcare or public program coverage. As previously noted, it is critical that these exchanges be designed in a way that allows consumers both inside and outside of the exchanges to make meaningful apples-to-apples comparisons among insurers and providers. That is the key to unleashing the power of consumer choice.

Evidence: Consumer-Directed Healthcare

How much more can we bring consumer choices to bear in lowering healthcare costs? An effective strategy for unleashing cost-conscious consumer choice is value-based benefit design[54] that provides consumers with incentives to use certain types of treatments or providers.

Reference pricing is another strategy that may be promising in terms of bringing down healthcare costs. Reference pricing asks questions such as, "When does it make sense to pay more for an x-ray—or even a knee replacement—at one facility, when a consumer can get a less expensive, identical procedure at a facility down the street?" The Pacific Business Group on Health (PBGH) is working with purchasers to help them gather price data on specific procedures. It then plans to work with purchasers to help them design benefits that encourage consumers to use the facilities that offer the best value services. In the coming year, its efforts will be expanded into working with health plans to encourage them to design suitable programs in this area, as well as working with members that design their own health plans.

Some strategies to bring down costs through the use of market mechanisms, though, have significant risks and have had uneven results.[55] Health savings accounts, high deductible health plans, and other forms of "consumer-directed healthcare" have been effective at bringing down short-term healthcare costs, particularly for employers. However, they also may be in part responsible for the rise in overall healthcare costs. The evidence indicates that consumers, when they are highly sensitive to price at the point of services, tend to skimp on needed primary and preventive care. That this is the case should be no great surprise.

---

[54] James C. Robinson, 2010, "Applying Value-Based Insurance Design To High-Cost Health Services," *Health Affairs*, 29, no.11: 2009-2016; Teresa B. Gibson et al, 2011, "A Value-Based Insurance Design Program At A Large Company Boosted Medication Adherence For Employees With Chronic Illnesses," *Health Affairs*, 30, no.1: 109-117; Ha T. Tu and Johanna Lauer, November 2009, "Impact of Health Care Price Transparency on Price Variation: The New Hampshire Experience," Center for Studying Health System Change, Issue Brief No. 128.

[55] See e.g., Petra Steinorth, March 2011, "Impact of health savings accounts on precautionary savings, demand for health insurance and prevention effort," *Journal of Health Economics*, Volume 30, Issue 2: 458-465; A. Mark Fendrick and Michael Chernew, "Value-Based Insurance Design: A 'Clinically Sensitive, Fiscally Responsible' Approach to Mitigate the Adverse Clinical Effects of High-Deductible Consumer-Directed Healthcare," *Journal of General Internal Medicine*, Volume 22, Number 6: 890-891.

Making the Market for Healthcare Work

One of the key principles of a competitive marketplace is that there are not "asymmetries of information" between buyers are sellers. What this means is that each should know roughly as much about the product being sold, or there should not be insurmountable barriers to buyers learning what they need to know in order to make informed choices.

This task is difficult enough when the purchase relates to health insurance: there are many different terms for people to learn (e.g., deductible, coinsurance) and these terms are sometimes used by sellers in inconsistent and opaque ways. Federal healthcare reform takes many steps to empower consumers to better understand their options, and the health benefit exchanges, if properly structured, may also help create a competitive market.

There are greater challenges to using price sensitivity at the point of service to drive down healthcare costs. The first is that the vast majority of healthcare costs are accrued in emergency, end-of-life, or chronic disease management situations. In these cases it is either impossible (in the case of emergency), extraordinarily difficult (in the case of end-of-life) or counterproductive (in the case of chronic disease), to shop around as one might shop for a used car or the best airline deal.

There is also too much to know about medical care for it to be reasonable to expect that consumers will be able to effectively bargain with providers about the price or amount of care they are receiving. People now have much more information, both through television commercials and the Internet, about what treatment options are available to them. To the extent that we have evidence about the impact of this increased information from television advertisement in particular, the indications are that it increases consumers' demands for medical treatments—often for treatments that have little proven effectiveness for their particular conditions.[56]

There is some evidence that consumers have begun to become somewhat more price sensitive during the course of their care but also that increased price sensitivity may lead them to avoid necessary care such as childhood immunizations.[57] It is more effective over the long-term to engage consumers when they are choosing among high-value integrated delivery system rather than when they are selecting among different healthcare services of unknown value. Hence the necessity of providing

[56] Barbara Mintzes et al, February 2002, "Influence of direct to consumer pharmaceutical advertising on patients' requests on prescribing decisions: two site cross sectional survey," *British Medical Journal* Volume 324.

[57] Amelia M. Haviland, Neeraj Sood, Roland D. McDevitt, and M. Susan Marquis, 2011, "The Effects of Consumer-Directed Health Plans on Episodes of Health Care," Forum for Health Economics & Policy: Vol. 14: Iss. 2 (Health Policy), Article 9.

good cost and quality information to enrollees in exchanges run both by the state and by large employers.

Wellness

We have, at this point, decades of evidence on what works to promote wellness among the employees of large organizations. The key takeaway is that wellness programs have some promise but that it is important not to depend on these strategies too much. In particular, major concerns have been raised as to whether these programs are capable of having any long-term success in combating obesity. However, they remain an essential part of a multi-pronged strategy to reduce costs and improve people's health and well-being. Employers and public agencies have had the most success focusing on areas such as smoking cessation.

Through the field of behavioral economics, we have also learned a great deal about how to structure wellness incentives to achieve optimal outcomes.[58] At least 40% of premature deaths are the result of unhealthy behaviors such as smoking, poor diet, or inadequate physical activity. Though there is a widespread understanding of the health risks of these behaviors, people often have difficulty trading immediate gratification for the reduction of a risk they perceive as being far in the future. One potential solution is to offer immediate rewards for improved health behaviors. This can include reduced insurance premiums, a strategy pioneered by Bay Area-based companies such as Safeway, or direct cash payments to employees. In one study involving these payments, the test group, when compared to the control group, showed significant improvement in the vital signs such as blood pressure and lipid levels in the test group in just four months.[59]

Social Determinants of Health

Most of the strategies described in this report focus on how to realign the incentives for healthcare providers to deliver medical care more efficiently and to direct their energies toward maximizing wellness. However, many of the factors that drive the rapid increase in healthcare costs are outside of the healthcare system and involve the choices that people make about the food that they eat and the activities they engage even more than they involve their choices about when to access medical care.

When people consistently engage in unhealthy behaviors, they greatly increase the chances that they will develop chronic diseases early in life. The chronic diseases that are responsible for the vast majority of medical

[58] Kevin G. Volpp, February 2009, "Paying People to Lose Weight and Stop Smoking," Leonard Davis Institute of Health Economics, Issue Brief: Volume 14, Number 3.

[59] Kevin Volpp et al, 2008, "Financial Incentive Based Approaches for Weight Loss: A Randomized Trial," *Journal of the American Medical Association*, Volume 300, Issue 22: 2631-2637.

spending—coronary artery disease, congestive heart failure, diabetes and depression—are all linked to obesity, which is, in turn, largely a product of choices about diet and physical activity.

These choices, though, are too often a product of the environments that people live in. Neighborhoods and communities across our state vary greatly in terms of the extent to which they provide options for healthy food choices and safe spaces to walk and run. Too many of our communities are "designed for disease," with a fast food restaurant on every corner but no accessible supermarket or farmers' market. The California Center for Public Health Advocacy and the UCLA Center for Health Policy Research have shown that there is a strong link between obesity and the lack of accessibility to healthy food.[60]

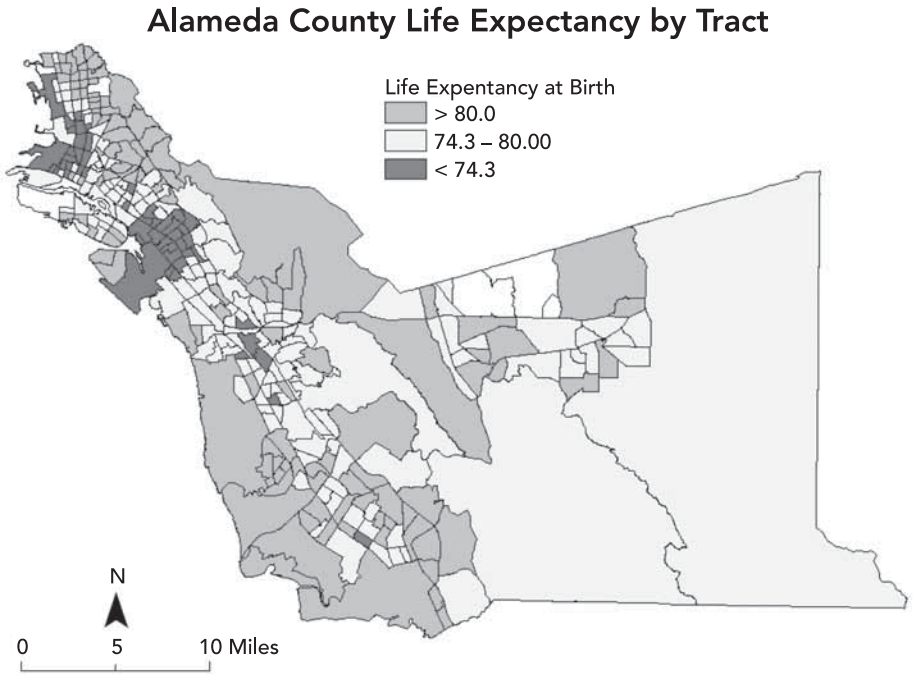
The rapid rise in obesity, particularly among children, is linked very closely to the consumption of soda and other calorically-enhanced beverages. A report by the California Center for Public Health Advocacy showed that soda consumption varies dramatically from county to county and city to city in California, and that rates of obesity and diabetes correlate with levels of soda consumption even when controlling for other factors. The report documented that forty-one percent of children ages two to eleven consume at least one soda per day, with rates almost double that amount in some cities and counties. A single twenty-ounce soda contains approximately seventeen teaspoons of sugar.[61]

The end results of the choices that Californians make, shaped by the environments in which we live, are inescapable. Right in the Bay Area, an affluent region, the difference in life expectancies among people living just a few miles apart is shocking. The Bay Area Regional Health Inequities Initiative has shown that "people who live in West Oakland...can expect to live on average 10 years less than those who live in the Berkeley Hills. Similarly, people who live in Bayview/Hunters Point can expect to live on average 14 years less than their counterparts on Russian Hill, while residents of Bay Point can expect to live on average 11 years less than people in Orinda."[62]

[60] California Center for Public Health Advocacy, PolicyLink, and the UCLA Center for Health Policy Research, April 2008, "Designed for Disease: The Link Between Local Food Environments and Obesity and Diabetes." UCLA Center for Health Policy Research, California Center for Public Health Advocacy, 2006, "The Economic Costs of Overweight, Obesity, and Physical Inactivity Among California Adults."

[61] "Bubbling Over: Soda Consumption and Its Link to Obesity in California," *California Center for Public Health Advocacy/UCLA Center for Health Policy Research*, September 2009.

[62] Bay Area Regional Health Inequities Initiative, *Health Inequities in the Bay Area*. 2008.



Source: CAPE, with data from vital statistics 1999–2001; see Bay Area Regional Health Inequities Initiative, *Health Inequities in the Bay Area*, 2008.

Therefore, choices made by the California Legislature and other policymakers that help improve the environments people live in—from addressing public safety to increasing access to high-nutrient food—also have an essential role in combatting rising healthcare costs. So do the messages that we send to our children and the choices that we make about food consumption and exercise. Hence, even quality public education is essential to combatting rising healthcare costs since children must receive positive signals, both in their schools and in their homes, about the health consequences of the choices that they make.

It is not possible to develop a medical system that is adequately efficient to resolve California's affordability crisis if a large percentage of people are developing diabetes—and conditions that often come along with obesity such as depression—in their 30s and 40s. Our current food environments and the individual choices we make are creating a tidal wave of disease that our medical system cannot handle effectively and equitably. Californians, therefore, must become much more engaged in improving their own health and taking personal responsibility for bringing down their own lifetime healthcare costs so that resources are preserved for those truly in need.

Actions

- *Unleash the power of cost-conscious consumer choice.*
  All businesses and other healthcare purchasers should, when feasible, give employees choices between different healthcare networks that are competing transparently on price and quality. The goal is for this level of choice to be available for people purchasing health insurance through their employers both inside and outside of the small group exchange as well as for fully insured and self-insured large businesses. All consumers should have the ability to select coverage options competing to provide the best value: high quality health insurance at an affordable price.

- *Employ proven value-based benefit design strategies.*
  Through the adoption of proven value-based benefit designs, healthcare purchasers should provide consumers with incentives to use certain types of treatments and providers. Preference should be given to strategies that have begun to demonstrate their value, such as reference pricing.

- *Adopt wellness programs in all businesses.*
  All businesses should put in place the types of wellness programs that have shown results. These wellness programs are generally focused on engaging consumers in activities rather than simply assessing their vital statistics. Federal healthcare reform includes grants for wellness programs for small businesses. To the extent that these wellness elements are becoming a market standard, the Board of the Exchange could make those elements part of the requirements to be a Qualified Health Plan.

- *Empower Californians to make healthy choices.*
  Enabled by policies that expand access to healthy foods and safe communities, all Californians must urgently take personal responsibility for maximizing their own health and wellness by making healthier choices. The healthcare affordability crisis is driven by the price of medical care but we, as consumers and businesses, can vastly diminish our need to access this medical care by improving our own health.

Conclusion

Developing Efficient, Effective Systems of Care

To achieve both short-term affordability and long-term sustainability in medical spending, we must build on the central element of the California system that has kept cost growth down: the development and growth of **high-performing health systems** that maximize wellness and efficiently deliver high-quality patient care.

A system capable of delivering high-quality, affordable care:

- Has the financial incentive to maximize patient wellness, not intensity of services;
- Makes meaningful use of health information technology;
- Integrates the work of its healthcare providers;
- Effectively manages care for chronic disease;
- Promotes patient safety;
- Humanely manages end-of-life care;
- Engages consumers with transparent information and incentives for wellness; and
- Has efficient administration.

Each of these characteristics of a high-performing system works best in coordination with the others. **There is no silver bullet for controlling the rise of medical costs**. Payers, therefore, must partner with provider networks capable of delivering these elements at an affordable price.

We all have a stake in the creation of high-performing health systems for our communities. This report is intended to serve as a handbook for engagement, providing the best evidence on what works and what doesn't as we confront the challenge of providing affordable, universal healthcare.

201 California Street, Suite 1450, San Francisco, CA 94111
(415) 981-7117 ♦ Fax (415) 981-6408
www.bayareaeconomy.org ♦ bacei@bayareacouncil.org

The Bay Area Council Economic Institute is a partnership of business, labor, government, higher education and philanthropy, that works to support the economic vitality and competitiveness of the Bay Area and California. The Association of Bay Area Governments is a founder and key institutional partner. The Economic Institute also supports and manages the Bay Area Science and Innovation Consortium (BASIC), a partnership of Northern California's leading scientific research laboratories and thinkers. Through its economic and policy research and its many partnerships, the Economic Institute addresses major issues impacting the competitiveness, economic development and quality of life of the region and the state, including infrastructure, globalization, science and technology, and governance. A public-private Board of Trustees oversees the development of its products and initiatives.

The Bay Area Council is a business-sponsored, public-policy advocacy organization for the nine-county Bay Area. The Council proactively advocates for a strong economy, a vital business environment, and a better quality of life for everyone who lives here. Founded in 1945, as a way for the region's business community and like-minded individuals to concentrate and coordinate their efforts, the Bay Area Council is widely respected by elected officials, policy makers and other civic leaders as the regional voice of business in the Bay Area. Today, more than 275 of the largest employers in the region support the Bay Area Council and offer their CEO or top executive as a member.

201 California Street, Suite 1450
San Francisco, California 94111
P 415.981.7117 F 415.981.6408
www.bayareaeconomy.org
bacei@bayareacouncil.org