PrimaryCare Learning Network

2015 Health Care Value Forecast:
Payers, purchasers and providers

How much does health care cost?

FEATURING
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Forecast

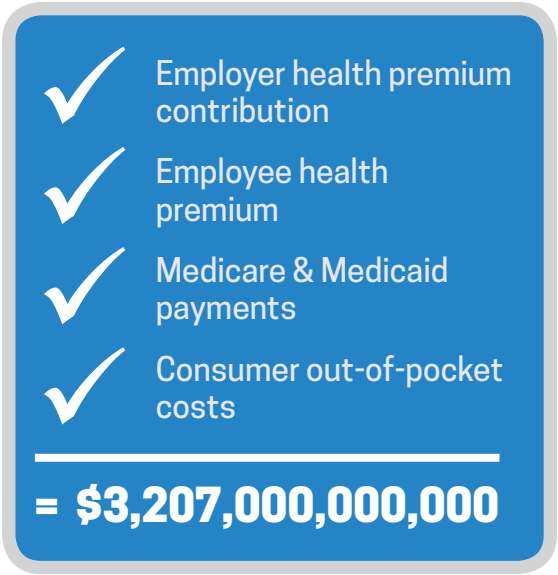
How much does health care cost?

The short answer is staggering: In the U.S., we will spend $3.207 trillion in 2015.[1] That's $3,207 with nine zeroes behind it—a number so large that it's nearly impossible to comprehend. Think of it this way: If you had a dollar for every second that passed, it would take you 101,693 years to accumulate $3.207 trillion.

As of this writing, the U.S. total population is 321.2 million. With a new person added to our census every 12 seconds, we are fast approaching health care costs totaling $10,000 for every man, woman and child living in the U.S.[2]

That's $10,000 for each of us, *every year.* For employers, that's an expense allocated to benefits rather than wages.

Consumers are becoming aware of the high cost of health care *coverage*—the cost to have *insurance*, that is. But awareness comes with a price. High-deductible health plans are becoming more common; 83 percent of employers now offer them, and 31 percent of employers that do say it's their most popular plan offering to employees.[3] An increase in high-deductible coverage means more money out of the employees' own pockets. Total premium costs for all types of plans are also up; between 2004 and 2014, worker contributions for family health care coverage rose 81 percent.[4]



Most individuals who seek coverage from either state or federally run health insurance marketplaces are choosing from a range of high-deductible plans as well.[5] The average deductibles on these marketplaces during the 2014-2015 enrollment period were more than $5,000 for an individual and $10,500 for a family on a Bronze Plan.

But the link between insurance premiums and out-of-pocket deductibles does not always translate to an awareness of health care prices—what the supply side is charging

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1 Munro, D. "U.S. Healthcare Spending On Track To Hit $10,000 Per Person This Year." *Forbes*. Jan. 4, 2015. http://www.forbes.com/sites/danmunro/2015/01/04/u-s-healthcare-spending-on-track-to-hit-10000-per-person-this-year/

2 Ibid

3 Health and Well-being Touchstone Survey Results. PricewaterhouseCoopers, June 2015

4 Premiums and Worker Contributions Among Workers Covered by Employer-Sponsored Coverage, 1999-2014 Kaiser Family Foundation. http://kff.org/interactive/premiums-and-worker-contributions/

5 Herman, B. "High deductible plans dominate next open enrollment." *Modern Healthcare,* Nov. 13, 2014 http://www.modernhealthcare.com/article/20141113/NEWS/311139966

for services. Nor does it offer consumers information with which to make value-based choices in medical care—quality indicators and customer satisfaction ratings.

While the cost of coverage has received ample attention since passage of the ACA, there is still precious little discussion about health care prices—the amount hospitals, clinicians and pharmacies charge for the medicines and services we receive. "To be specific, there's not a good understanding of the drivers of cost—what makes prices increase—or the variability of price from one provider to another," says Wendy Lynch, Ph.D., Altarum Institute fellow. While there are ample reasons why this knowledge gap exists among consumers, there are ways for employers—still the majority payer for health care coverage in the country—to change this course.

> "Culturally, Americans don't like to question doctors about health care value. There is a pervasive perception that physicians are not business people. In truth, they are professionals who intend to make a good living, just like every other professional, and it is naiveté to believe they aren't seeking to maximize their revenue."
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Where's the price tag?

In 2009, Atul Gawande, MD, put a magnifying glass on the high cost of health care in one Texas town.[6] In McAllen, Texas, Medicare spent $15,000 per enrollee on care in 2006—twice as much as the national average, and $3,000 more per person than the average McAllen resident earned.

For that price, you would hope McAllen's hospitals were delivering better quality care than in comparable communities, but they were not. And residents in McAllen were no more obese or prone to chronic disease than the national average. Providers couldn't blame their sky-high charges on an overactive malpractice environment either. The culprit was overuse of resources—more testing, more specialist visits, more invasive diagnostic studies.[7]

Most ensuing press coverage focused on greedy, over-prescribing doctors. There is some evidence for that; seven McAllen doctors paid $28 million in a settlement when it was discovered they were receiving kickbacks for certain specialist referrals.[8] But the cause for high prices in McAllen is more about lack of price transparency.

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[6] Gawande, A. "The Cost Conundrum: What a Texas town can teach us about health care." *The New Yorker,* June 1, 2009 http://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum

[7] Ibid.

[8] Mangan, D. "This magazine article saved $500M in unnecessary Rx spending." CNBC, May 8, 2015. http://www.cnbc.com/id/102662620

just like every other professional, and it is naiveté to believe they aren't seeking to maximize their revenue." If providers can do more procedures or offer more expensive services—that are allowed, accepted and covered by insurance—what's the harm? "We aren't talking about scams, just normal practice. They are responding precisely as they should, to a health care market that still pays for volume over value."

The real issue is that patients don't have the opportunity to compare value, and they aren't in the habit of asking price questions when it comes to health care.[9] In fact, fewer than 50 percent of consumers have ever asked about the price of a health care service before receiving the service.[10] The same mother of three who pinches pennies at the grocery store won't blink an eyelash when the orthopedist says she needs a $50,000 knee replacement surgery—primarily because the doctor doesn't care to tell her how much it will cost (or may not even know how much it will cost). In any case, she finds it distasteful to ask in our current culture—instead, relying on the trusted professional: "the doctor says I need it." And if she has already reached her health plan deductible for the year, there is no expensive consequence to pay.

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There remains a big disconnect between evidence and what consumers believe about their own doctors. While experts believe that one-third of all health care services are unnecessary, 71 percent of consumers believe their own doctors would never recommend a service that wasn't necessary.[11,12]

A billion here, a billion there, pretty soon you're talking about real money

Most patients are also unaware of the range of choices that could lower the cost of that knee surgery (for example), or render it completely unnecessary. For instance, the cost of an MRI performed conveniently within the orthopedic practice may cost significantly more than the exact same test run in an ambulatory imaging center.[13] And, if her knee problem was caused by arthritis, she may benefit from trying physical therapy before surgery.[14] Or, if her employer is savvy, she might fly to another state or country,

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9 Value in health care (in this context) considers both cost and quality.

10 Center for Consumer Choice in Health Care Research Findings, Fall 2014. http://altarum.org/our-work/center-for-consumer-choice-in-health-care-research-findings%E2%80%94fall-2014#sthash.qmUKv54Q.dpuf

11 "Choosing Wisely: About the Campaign." ABIM Foundation, 2015. http://www.choosingwisely.org/wp-content/uploads/2015/04/About-Choosing-Wisely.pdf

12 CCHC Survey, Fall 2014, op. cit.

13 Ashford, K. "What I Learned When I Asked How Much My MRI Would Cost." *Forbes*, Oct. 31, 2014. http://www.forbes.com/sites/kateashford/2014/10/31/how-much-mri-cost/

14 Martin, G. "Alternatives to knee surgery." Wolters Kluwer Health, March 3, 2014. http://www.uptodate.com/contents/total-knee-replacement-arthroplasty-beyond-the-basics

get the same surgery performed for thousands of dollars less, and enjoy a week or two of recovery in a nice hotel.[15]

"The usual cost-benefit equation most of us apply to everything from buying a car to sending a kid to college is rarely applied to our own health care issues," Lynch says.

The way medications are prescribed in our system is also out of alignment with a cost-benefit mindset. New drugs are approved by the FDA if they perform safely and more effectively than drugs already on the market for the same use. Providers tend to prescribe, and patients tend to ask for, the newest and "most effective" medicines, even if the new drug performs only a few percentage points better and costs hundreds or thousands of dollars more per dose. "As consumers, we don't deal with these realities, because it's hard to argue against the idea that a better outcome at any cost is worth any price," she says.

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Misalignment of incentives to lower health care costs—among hospitals, physicians, the drugs we are prescribed, other health care providers, health plans and even federal agencies—is the pervasive problem.[16] In January 2015, the Centers for Medicare & Medicaid announced plans for an accelerated shift towards value-based reimbursement for Medicare services—as "incentives to motivate higher-value care."[17] It follows that a new sense of consumerism in health care—shopping for *value*—should be part of the solution.

Value must be transparent

Value in health care resides at the intersection of cost and quality.[18] For decades, employers have worked with providers and health plans to get clear, comparable information so employees can consider prices and provider quality ratings to enable better buying decisions. Recent examples demonstrate that ongoing access to information to make buying decisions—transparency in cost and quality—is not only possible, but that the positive results are magnified when augmented by consumer activation and empowerment.[19]

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[15] Terhune, C. "Companies go surgery shopping." *Los Angeles Times,* Nov. 17, 2012. http://articles.latimes.com/2012/nov/17/business/la-fi-bargain-surgery-20121117

[16] "Innovative approaches to lowering costs and improving outcomes." Institute of Medicine Value Incentives Learning Collaborative. http://iom.nationalacademies.org/Activities/Quality/VSRT/Innovation-Collaboratives/Value-Incentives.aspx?page=1

[17] Japsen, B. "White House Plans to Shift Medicare Away From Fee-For-Service; 50% Of Payments Tied To Quality By 2018." *Forbes*, Jan. 26, 2015. http://www.forbes.com/sites/brucejapsen/2015/01/26/medicares-bolt-from-fee-for-service-means-50-percent-value-based-pay-by-2018/

[18] Porter, M. "What is Value in Health Care?" *The New England Journal of Medicine,* Dec. 23, 2010

[19] Lynch, W. and Smith, B. *Steering Employees Toward Safer Care.* Altarum Institute, 2012. http://www.hospitalsafetyscore.org/media/file/SteeringEmployeesSaferCare_LeapFrog_WhitePaper.pdf

Forecast

For example, employees of the state of Maine can choose a hospital in a preferred network that meets quality targets, cost efficiency criteria and patient satisfaction levels, and pay a lower out-of-pocket cost than they would pay to go outside the network. That means a $20,000 procedure might result in a $5,200 ($1,500 deductible plus 20 percent) out-of-pocket cost at one hospital, but only $1,225 ($300 deductible plus 5 percent) at a high-performing hospital. The ability to choose a provider based on value is only possible because Maine's State Employee Health Commission adopted a purchasing strategy intended to steer employees to hospitals that met safety, quality, cost and satisfaction criteria. Although only nine hospitals in Maine met the preferred provider criteria when the program started, pressure from consumers and employers has systematically persuaded more hospitals to step up; today, 29 of 36 Maine hospitals meet the preferred status standards for quality, safety and cost.[20]

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The approach pulls three levers available to employers: benefit design, financial incentives to steer consumers to high performing providers, and information to educate health care buyers so they can make informed, prudent buying decisions.

"The state of Maine held 60 training sessions around the state to make clear the differences in quality, cost and patient safety between preferred and non-preferred hospitals," Lynch says. "State workers loyal to their local hospitals went to facility leadership and complained they would need to travel several hours to another town because their local hospital wasn't preferred." By making the pricing, quality and safety measures available and actionable—understandable to consumers—the initiative informed consumers to not only make a conscious decision based on value, but also to push reticent providers to become part of the network.

Safety differences are easily understood by consumers. Hospital safety varies widely among facilities; an estimated 100,000 people die every year as a result of medical errors. In cases where errors are not deadly, they can lead to longer hospital stays, more time away from work and lost productivity.

The latter are often overlooked in the cost equation. In a recent study of the total financial impact of employee absences, direct costs were pegged at 15.4 percent of total payroll, and indirect costs—productivity loss and replacement cost—were an additional 6.2 percent. Employers who consider employee health benefits as a cost center in isolation

[20] Ibid.

from the company's bottom line should take a serious look at the 22 percent total cost of absences. "If an unplanned hospital stay or longer recovery time attributed to health care errors occurs one in three times a patient is admitted, isn't it time to steer employees to the safest, most effective care?" Lynch asks.

Looking forward: Employers equip consumers to shop for value

Consumer awareness may well begin with the realization that the cost of health care is not the same as the cost of health insurance; insurance is merely a mechanism for paying for care, and it's affected by inefficiencies in the delivery system. "Too often, employees equate access to insurance as permission to spend without consideration of the alternatives. When consumers abdicate that responsibility, it raises the cost of care and the cost of insurance coverage," Lynch says.

> Providing convenient access to primary care is one of the most straightforward means to reduce absenteeism through preventive screening, lower overall costs and improved care for chronic conditions.

Follow-up and visibility, clear communication and incentives to choose better care are avenues for employers to advance awareness and shift the conversation from "how much does my health insurance cost" to "what part do I play to achieve better health, better care and lower costs."

- **Follow-up and visibility.** Employers can offer information on cost, quality and research on appropriateness of care. Such information is available from both health plans and independent vendors. They should regularly communicate with employees, teaching them to become prudent buyers of care and to recognize that preventive maintenance is a long-term investment in personal health.

  This is particularly helpful for routine minor issues and tests—but even here, costs can vary significantly across providers.[21] Research consistently shows a relationship between better access to primary care services and improved outcomes and lower costs.[22,23,24,25] Telemedicine services are also good options for basic, acute health care needs, Lynch says. Providing convenient access to primary care is one of the most straightforward means to reduce

[21] *MGMA Cost Survey: Key Findings Summary Report.* 2014 results. Medical Group Management Association. http://www.mgma.com/Libraries/Assets/Key-Findings-CostSurvey-FINAL.pdf?source

[22] *How is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care.* American College of Physicians (evidence review) 2008

[23] Starfield B., et al. "Contribution of Primary Care to Health Systems and Health." *Milbank Quarterly,* Sept. 2005

[24] Starfield B., and Shi L. "The Medical Home, Access to Care, and Insurance: A Review of Evidence," *Pediatrics*, vol. 113, no. 5, 2004

[25] "Access Is the Answer: Community Health Centers, Primary Care & the Future of American Health Care." National Association of Community Health Centers, March 2014

absenteeism through preventive screening, lower overall costs and improve care for chronic conditions.[26,27]

Consumers should expect communication and follow-up for prevention activities from primary care generalists. Employers can enable this with worksite-based efforts—a flu shot clinic provided at the worksite, or arrangements for employee care through preferred primary care clinics, for example—to support accessibility and demonstrate that employee's health is valued.

Lynch says creating a healthy workplace environment may be the most important contribution employers can make.[28] "Well-lit staircases and safe walking areas support employees who want to be physically active. Smoke-free policies encourage tobacco cessation. Healthy food choices in the cafeteria, priced to compete with unhealthy choices, are consistent reminders that employee health matters." These factors liberate employees to become champions of their own health, and they validate employees, not the employer, as the master of their personal health and well-being.

- **Clear communication.** Employers should provide tools to educate employees about how to buy health care services wisely, and how to use health benefits to their best advantage. It is important to offer information that allows them to find safer and higher quality hospitals (see sidebar). Because it's

Resources for Employers and Employees

- **Blue Distinction Center Finder:** www.bcbs.com/innovations/bluedistinction/center-list/selector-map.html
- **CMS Hospital Compare:** www.hospitalcompare.hhs.gov
- ***Consumer Reports* Health Ratings:** www.consumerreports.org/health/home.htm
- **HealthGrades:** www.healthgrades.com/
- **Hospital Safety Scores:** www.hospitalsafetyscore.org
- **Leapfrog Hospital Survey Results:** www.leapfroggroup.org/cp
- **ShareCare:** www.sharecare.com
- **The Commonwealth Fund's quality information website:** www.whynotthebest.org/
- **Healthcare Bluebook:** healthcarebluebook.com

[26] Hixon T. "Healthcare Costs: Low-Hanging Fruit," *Forbes*, April 4, 2014

[27] Klemes A, Seligmann RE, Allen L, Kubica MA, Warth K, Kaminetsky B. "Personalized preventive care leads to significant reductions in hospital utilization." *Am J Manag Care.* 2012 Dec 1;18(12):e453-60

[28] Touchstone Survey Results. PriceWaterhouseCoopers, June 2015, op. cit

[29] Robinson J., MacPherson K. "Payers Test Reference Pricing And Centers Of Excellence To Steer Patients To Low-Price And High-Quality Providers." *Health Affairs,* September 2012 vol. 31 no. 9 2028-2036

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natural to equate higher prices to better care, communication must paint an evidence-based picture using local examples.

Employee communication should start with the basic tradeoff made between salary and benefits. What is the percentage the employer pays for health benefits? When health costs go up, and the employer pays a portion of the increase, how does that squeeze what's left on the balance sheet to pay out in employee raises or bonuses?

"The first conversation employers need to have with employees is that the more health care costs go up, the more constraint there is on all the other ways they get compensated. Everybody is in this together," Lynch says.

- **Incentives to choose better care.** Incentives take many forms, like lower co-pays and deductibles for using preferred providers, or introduction of preferred provider networks based on quality, safety and cost factors.

  Reference-based pricing and contracting for centers of excellence in benefit design is another way to use incentives to keep costs low. California Public Employees' Retirement System, Safeway supermarkets and Lowe's Home Improvement all worked with their payer partners to spur employees to make decisions based on value.[29] With reference-based pricing, the patient is given a list of providers and their charges for a given procedure that varies widely in price (such as cataract surgery) and then given a maximum, or reference price, the payer will allot for the procedure. Any part above the reference price is the responsibility of the patient. Reference-based pricing puts market forces in play, and can result in the cost of procedures actually dropping across providers.[30]

Lynch says employers who value employees demonstrate it with benefits designed to engage them in being successful at work, while protecting their own health and well-being.

"You invest in the person on the job with training and rewards for getting the work done," she says. "Then you align benefits so it matters more for employees to show up and stay healthy. You align the absence policies as paid time off policies instead of sick leave. You align health benefits to have higher deductibles and funded health savings accounts so that when employees are healthy, they're saving money for retirement. You want both the employer and the employee to gain from high performance, regular attendance and good health. Everyone wins."

[30] Robinson J., Brown T., Whaley C. "Reference-Based Benefit Design Changes Consumers' Choices And Employers' Payments For Ambulatory Surgery." *Health Affairs,* March 2015 vol. 34 no. 3 415-422

Forecast

For 30 years, Wendy Lynch has been making the connection between human and business performance. Her career has included roles as faculty at the University of Colorado Health Sciences Center, senior scientist at Health Decisions International, and principal at Mercer Human Resource Consulting.

Lynch runs a consulting firm focused on health and business performance. She has applied her skills in research design and evaluation to several pivotal studies in the fields of consumer engagement, health management, productivity assessment and human capital management.

A frequent speaker and the author of more than 50 articles and reports, she also has two books, *Aligning Incentives, Information and Choice* and *Who Survives: How Benefits Costs are Killing Your Company.* She holds a doctorate in research and evaluation methodology from University of Colorado Boulder.

About the Primary Care Learning Network

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