

CREATING VALUE THROUGH COLLABORATION

Lessons learned from past efforts to control health care costs

Overview

Health care costs continue to rise rapidly, and nearly a third of these costs are considered waste.¹ Many of the contributors to waste, such as overtreatment, missed prevention opportunities, and a lack of coordination of care, stem from a payment system that rewards health care providers for the quantity of services delivered (i.e., fee-for-service (FFS)) rather than the quality of services delivered (i.e., fee-for-value (FFV)). There is general consensus across the industry that health care cost increases are unsustainable and there is significant opportunity to improve the quality of care.

The U.S. government and several payers, providers, and employers have committed to accelerating the shift away from traditional FFS payment to value-based reimbursement models in order to improve the quality and affordability of health care. In January of 2015, HHS set a goal stating that by 2018²:

- 50% of FFS Medicare payments will be tied to “alternative payment models,” such as Accountable Care Organizations (ACOs) and
- 90% of payments will be tied to “value-based arrangements,” such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.

This is the first time in the history of the Medicare program that HHS has set explicit goals for value-based payments to providers. Since then, other payers and providers have followed suit and have set their own value-based payment goals. To successfully shift to a value-oriented health care system, it is important that both payers and providers consider lessons learned from past efforts to control health care costs – which focused on cost containment and physician payment mechanisms – and collaborate to drive improved health, affordability, and patient experience.

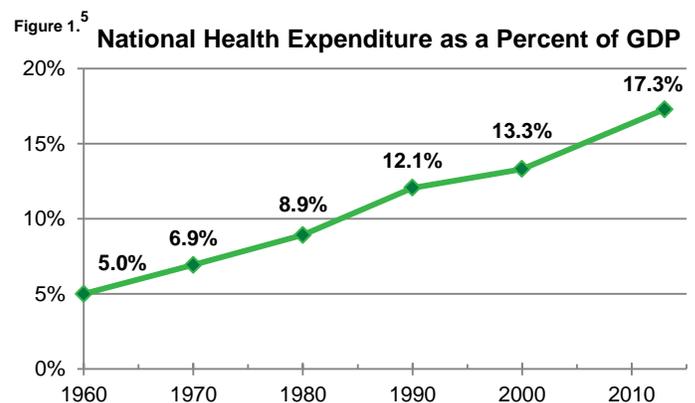
Background

Health care cost trends

Health care spending has increased significantly in the last 50 years. Health care expenditures as a percentage of gross domestic product (GDP) increased from 5% in 1960 to 17.3% in 2013.³ See Figure 1. Over the same period, health care spending grew an average of 5.5% per year while GDP only grew by 3.1% per year.⁴ Various factors have contributed to cost increases over time, and the U.S. government and health care industry have responded with regulatory, plan design, payment reform, and cost containment measures to try to reign in those costs.

Past efforts to control health care costs

Rapidly rising health care costs through the mid-1970s to the early 1980s drove employers to look for more affordable alternatives to traditional indemnity plans.⁵ Under indemnity plans, providers were paid for services delivered, without any provider choice restrictions for individuals. Managed care plans, such as Point of Service (POS) and Health Maintenance Organization (HMO) plans, arose as a solution. These plans selected providers to be “in network” and negotiated discounted rates with providers in exchange for patient volume. Managed care plans proliferated from the mid-1980s through the 1990s.⁶ Enrollment in HMO plans, in particular, grew significantly from 9 million individuals in 1980 to over 64 million by 1998, with more concentrated growth in the Western region of the U.S.⁷



1. Health Affairs & Robert Wood Johnson Foundation, Health Policy Brief, “Reducing the Waste in Health Care,” 12 December 2012.

2. U.S. Department of Health and Human Services, “Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value,” News, January 26, 2015.

3. Catlin, Aaron C. and Cowan, Cathy A., “History of Health Spending in the United States, 1960-2013,” 19 November 2015.

4. Ibid. These numbers have been adjusted for economy-wide inflation.

5. Ibid.

6. Frakt, Austin B., Mayes, Rick, Health Affairs, “Beyond capitation: how new payment experiments seek to find the ‘sweet spot’ in amount of risk providers and payers bear,” September 2012.

7. Catlin, Aaron C. and Cowan, Cathy A., “History of Health Spending in the United States, 1960-2013,” 19 November 2015.

In the 1990s, health care costs moderated as a result of the proliferation of managed care plans. These plans used various cost containment mechanisms to contain costs. For example, HMO plans focused on the following:

- › *Capitation* – HMOs paid physicians a fixed dollar amount for all care that patients received for a defined period of time (e.g., per patient per month/year) instead of paying for each service performed.
- › *Gatekeepers* – HMOs required primary care physicians (PCPs) to authorize visits to specialists for the visit to be covered by the plan.

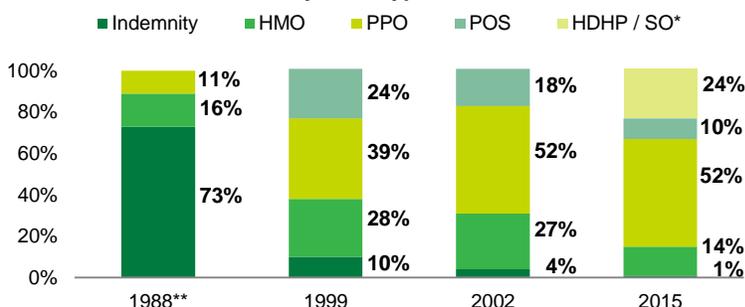
HMOs' cost control mechanisms yielded mixed results. On the one hand, capitation gave providers greater autonomy in care delivery. On the other hand, capitation resulted in greater financial risk for providers, as they were responsible for any costs incurred above the set payment. This increased financial risk led to provider consolidation and some providers treating patients more conservatively, potentially limiting necessary services. And while gatekeeping had potential as a care coordination mechanism, it was unpopular with physicians and patients because it delayed needed care and increased provider administrative burden.⁹

Transition to current market landscape

Through the early 2000s, health care costs increased again, largely as a result of prescription drug price growth, more rapid government health care spending, and HMOs falling out of favor.¹¹ Providers did not feel they received sufficient clinical support or data to take on financial risk and were burdened by the added administrative work. HMO enrollees were dissatisfied with the limited networks and high level of payer involvement in treatment decisions. For these reasons, employers sought to expand employee choice and HMO plans were largely abandoned in favor of less restrictive Preferred Provider Organization (PPO) plans, which remain the most common plan type today. See Figure 2.

Figure 2.¹²

Distribution of Health Plan Enrollment for Covered Workers by Plan Type, 1988 - 2015[†]



[†] Totals may not add to 100% due to rounding. *High-deductible health plan with a savings option (SO), e.g., HRA, HSA, ** POS very limited; information not available for 1988

Current environment

Some providers experienced success under capitated contracts in the 1990s and still maintain capitated contracts with payers today. However, many providers struggled with managing increased financial risk without the infrastructure and data to support it and ultimately pulled out of these arrangements.¹²

Today, providers are predominantly paid based on the volume of services delivered, and not the value of care delivered. However, there is momentum to transition to fee-for-value reimbursement, largely as a result of:

- › Broad recognition that health care cost growth is adversely impacting employers' and the US economy's ability to compete and that there is significant opportunity to improve health outcomes
- › Incentives provided through The Affordable Care Act (ACA) for new payment models that encourage coordination of care across providers (e.g. ACOs)
- › Big data and technology developments that have improved clinical and financial data systems, enabling improved data aggregation, analytics and exchange to help providers treat patients more effectively
- › HHS' announcement of value-based reimbursement goals, which signaled to the industry that value-based reimbursement is the future

Health Care Cost Drivers Today¹³

- › High utilization of expensive services (e.g., MRI)
- › Provider market power due to consolidation
- › Rising prescription (particularly specialty) drug costs
- › Overtreatment, particularly in end-of-life care
- › Unhealthy behaviors leading to a high level of chronic illness
- › Providers practicing defensive medicine to avoid lawsuits
- › Fragmented, uncoordinated care
- › High levels of fraud, waste, and abuse in the health care system

Provider interest in value-based reimbursement is increasing. However, adoption of true risk-based contracts remains low as many providers feel they lack the capabilities, such as data exchange, or competency required to manage risk. ACO growth continues, and existing ACOs are expanding the number of contracts they operate under and the level of risk inherent in the model.¹⁴ As of December 2015, there were an estimated 782 ACOs covering more than 23 million lives.¹⁵ Like the 1990s, the shift to value-based models is leading to increased provider consolidation. Unlike the 1990s, however, many providers are partnering through alliances and joint ventures rather than traditional mergers and acquisitions to achieve the clinical scale necessary to be successful in value-based models.

8. Bank of America Merrill Lynch, "Managed Care Primer 2014 – Analyzing a sector in transition," 22 April 2014.

9. Brody, Jane E., *The New York Times*, "Study Looks at Absence of Referrals by Doctors," 1 November 2001.

10. Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits, 2015 Annual Survey," 2015.

11. Catlin, Aaron C. and Cowan, Cathy A., "History of Health Spending in the United States, 1960-2013," 19 November 2015.

12. *Managed Care*, "Capitation: The Once and Future King," August 2015.

13. A Report by the State Health Care Cost Containment Commission, *The Miller Center – University of Virginia*, "Cracking the Code on Health Care Costs," January 2014.

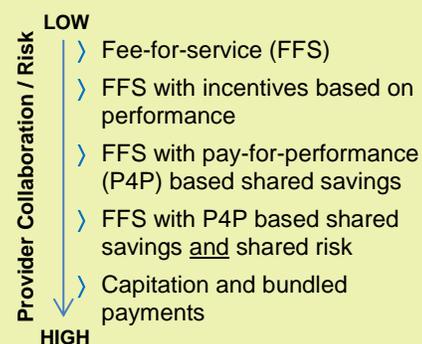
14. Muhlestein, David, Health Affairs Blog, "Growth and Dispersion of Accountable Care Organizations in 2015," 31 March 2015.

15. Muhlestein, D., et.al. *Leavitt Partners*, "Projected Growth of Accountable Care Organizations," December 2015.

How are today's efforts to control costs different than the 1990s?

Efforts to control costs in the 1990s focused on capitation and other cost containment mechanisms that often resulted in contentious relationships between payers and providers. Today, payers recognize that they need to support providers and help them succeed with value-based models, resulting in greater collaboration between these stakeholders. Payers are doing this by offering a range of value-based reimbursement models – from fee-for-services with performance-based incentives to capitation and bundled payments for a particular “episode of care” – that promote clinical accountability with a gradual increase in financial responsibility for providers. Additionally, value-based reimbursement is increasingly tied to cost *and* quality outcomes, and payers are providing clinical and cost data to support provider decision making. Below is a table comparing key differences between efforts to control costs in the 1990s and today.

Value-based reimbursement continuum



Comparing Eras

	1990s	Today
<i>Approach</i>	Narrow focus on reducing costs through capitation and other cost containment mechanisms (e.g., utilization management, gatekeeping) that increased provider administrative burden and denials	More broadly focused on collaboration between payers and providers and delivering value through a variety of plan designs and financial models
<i>Scope</i>	More prevalent in the West	Widespread – many payers/providers nationwide
<i>Physician Buy-in</i>	Limited – most physicians reacted negatively to the cost containment mechanisms	Broad – physicians recognize the opportunity to reduce costs and improve outcomes
<i>Consumer Engagement</i>	Emphasis on restricted choice to control costs	Emphasis on engagement, information, and incentives to guide consumers to value-oriented providers
<i>Provider Reimbursement</i>	Focus on financial risk transfer to providers with little to no support from payers	Focus on clinical accountability with gradual increase in financial responsibility; reimbursement takes into account differences in patient health status and demographic factors
<i>Enabling Technology</i>	Limited – first generation technology	Advanced technology, including widespread adoption of electronic medical records, health information exchange, and robust analytics
<i>Federal Stimulus</i>	HMO Act enabled new products	ACA created payment incentives and penalties based on performance and incentivized new models of care (e.g., ACOs, bundled payments); HHS issued value-based payment goals
<i>Urgency</i>	Economy recovered, easing financial pressure; this led to a shift away from tightly controlled HMO plans which were unpopular among consumers and doctors	Comprehensive coverage under ACA raises importance of affordable coverage; high costs are affecting global competitiveness

How do we position ourselves to succeed in the future?

Payers and providers each play a critical role in accelerating the transition from fee-for-service to fee-for-value. **Payers** must provide the right incentives for providers to take on population health management and the resources required for success, including:

- › Financial incentives that achieve desired outcomes and are significant enough to make it worth providers' efforts to implement change
- › Increased patient volume for providers achieved through products that guide patients to high value providers/networks, offer them financial incentives to use these providers, and engage them in health care decision making to optimize provider success
- › Resources, such as consultative clinical support and timely, actionable clinical and financial information that supports providers and allows them to focus on patient care
- › Engaged consumers. Payers can use health coaching, incentives, and decision support tools to engage consumers in their health care, which will help improve outcomes for providers
- › Products that address the elements of managed care that created backlash in the 1990s
- › Support for provider efforts to modify their service model (e.g., increased convenience, alternative models of care like telemedicine)

“Payer and provider collaboration and shared focus on doing what is best for the patient is essential to accelerate the transition to fee-for-value and achieve a high performing health care system.”
 - Richard Salmon, MD, PhD, National Medical Director, Performance Measurement and Improvement, Cigna

Providers must embrace value as a key part of their vision for future success, evolve their business models, and empower physicians and care teams to manage patient care across the care continuum. This includes:

- › Seeking value-based relationships with payers that are right for them and allow them to “dip their toe” in value-based payments and take on greater risk over time as they develop the competencies, experience, and infrastructure to be successful
- › Gaining buy-in from front-line staff for value-based models and providing individual physicians financial rewards tied to their performance
- › Investing in infrastructure, such as data exchange and analytics, that enables and empowers physician-led care teams to coordinate care across the continuum
- › Evolving their patient service model to offer convenience (e.g., extended hours, telemedicine, etc.), to improve patient satisfaction, trust, and retention
- › Utilizing advanced practitioners (e.g., nurse practitioners) as appropriate to reduce costs and increase physician capacity

Efforts to design value-based networks and affordable products must also consider whether there are localized physician shortages in particular geographies or specialties and ensure network adequacy and provider availability for consumers. Additionally, it is important to consider whether providers have capacity to take on additional patient volume that they may receive as a result of health plans’ value-based product designs.

How Cigna is helping accelerate the shift from volume to value

Cigna is committed to accelerating the shift away from traditional fee-for-service provider payments to value-based models that reward quality and health outcomes. In March 2015, we committed to the value-based payment goals set forth by HHS. These goals are aligned with our efforts to deliver improved health, affordability, and experience by effectively connecting the care delivered by providers to our customers.

To achieve our value-based payment goals, we continue to focus on enhancing our relationship with providers who are ready to embrace value-orientation by:

- › Designing products that provide customers access to quality, cost-effective providers in local markets and encourage customers to receive care through those providers.
- › Building collaborative, value-based relationships with providers across the delivery system (e.g., large and small primary care groups, specialists, hospitals, and integrated delivery systems) and meeting providers where they are in terms of risk readiness, experience, and other factors.
- › Working with providers to transition to more value-oriented models over time by bringing them the resources and support they need, including: timely, actionable data and reporting, clinical-based support services, aligned incentives, physician program support, and consumer health engagement programs.

Our models are oriented around total population health and improving quality, affordability, and satisfaction for our customers and clients. We are continuing to build more of these relationships and are launching new collaborative models focused on additional high cost specialties and small primary care groups. As we seek to create new provider collaboration models and programs that help improve quality, affordability and customer experience, it is important not to forget lessons learned from the past to help ensure success in the future.

Our Collaborative Relationships¹⁶

(Year End 2015)

- › > 140 large physician groups
- › > 300 individual hospital arrangements
- › > 30 specialty groups
- › 2 delivery system alliances (joint ventures with providers)

Together, all the way.®



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16. Cigna internal analysis of existing arrangements as of 12/31/2015. Subject to change.