BlueCross BlueShield of Texas

The Changing Health Insurance Landscape

PAUL D HAIN, MD, FAAP

PHM 2017

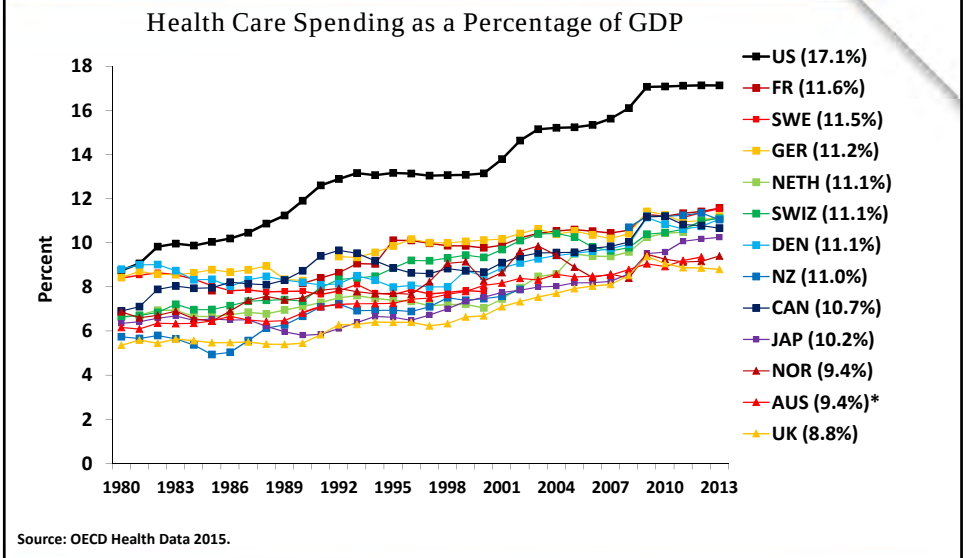
Disclosure

- I am an employee of Blue Cross Blue Shield of Texas.

BlueCross BlueShield of Texas

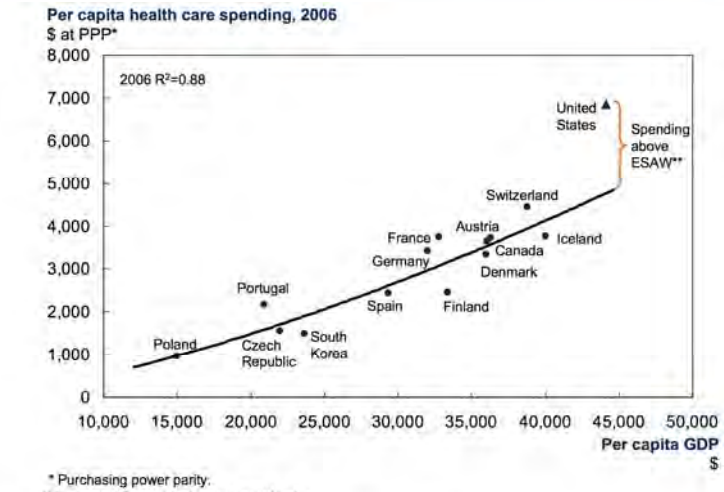
US Healthcare Costs

The Insomnia Inducer



Source: OECD Health Data 2015.

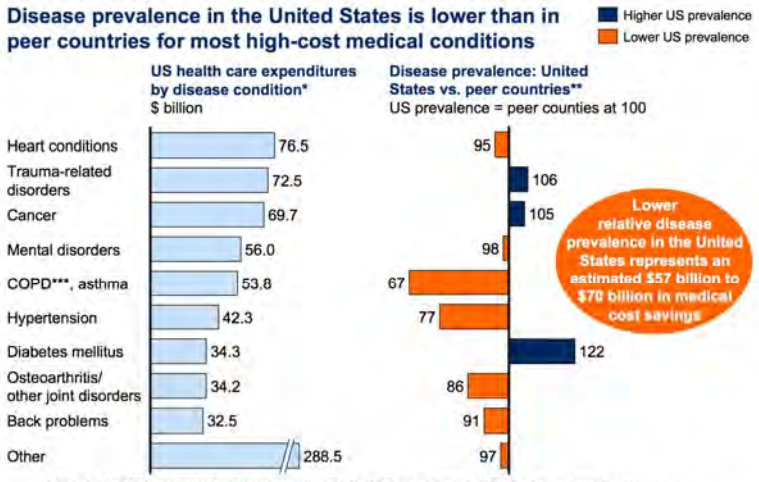
After Adjustment for Wealth, US Still Spends More Than Other Countries



* Purchasing power parity.
** Estimated Spending According to Wealth.
Source: Organisation for Economic Co-operation and Development (OECD)

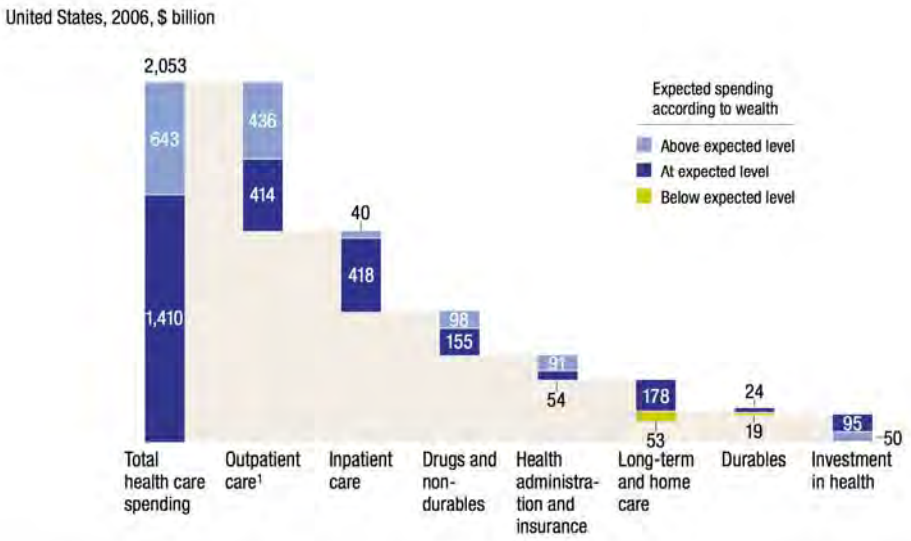
McKinsey Global Institute

But the US is not as sick as Europe



* Includes 35 of 60 medical conditions surveyed by US Medical Expenditure Panel Survey; the costs of these diseases represent 35 percent of total US health expenditures.
** Peer countries are France, Germany, Italy, Spain, and the United Kingdom.
*** Chronic Obstructive Pulmonary Disease.
Source: Medical Expenditure Panel Survey, 2005; Decision Resources 2006; McKinsey Global Institute analysis

Outpatient Spending Is Much Higher in the US than in Other Countries



It's The Prices, Stupid: Why The United States Is So Different From Other Countries

Higher health spending but lower use of health services adds up to much higher prices in the United States than in any other OECD country.

by Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan

HEALTH AFFAIRS ~ *Volume 22, Number 3*

US Costs: Point #1

- The primary driver of increased spending in the United States compared to other Developed Countries is **Higher Prices**

Robert Wood Johnson Foundation
The Impact of Hospital Consolidation

SUMMARY OF KEY FINDINGS

> **Hospital consolidation generally results in higher prices.**

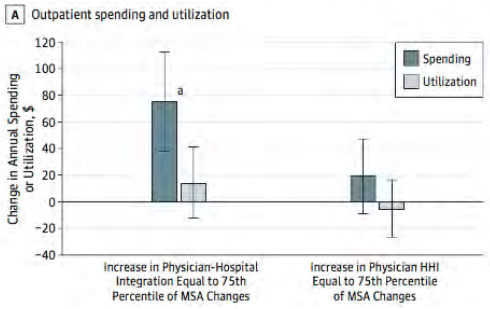
> **Hospital competition improves quality of care.**

> **Physician-hospital consolidation has not led to either improved quality or reduced costs.**

Robert Wood Johnson Foundation **UPDATE** June 2012

Original Investigation

Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices



"Increases in physician-hospital integration from 2008 through 2012 were associated with increased spending and prices for outpatient services, with no accompanying changes in utilization that would suggest more efficient care from better care coordination and economies of scale."

JAMA Intern Med. doi:10.1001/jamainternmed.2015.4610
Published online October 19, 2015.

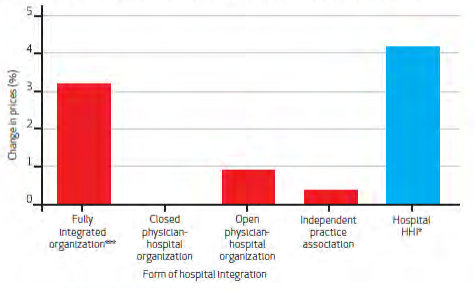
Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending

HEALTH AFFAIRS MAY 2014 33:5

Our most definitive finding is that hospital ownership of physician practices leads to higher prices and higher levels of hospital spending.

EXHIBIT 2

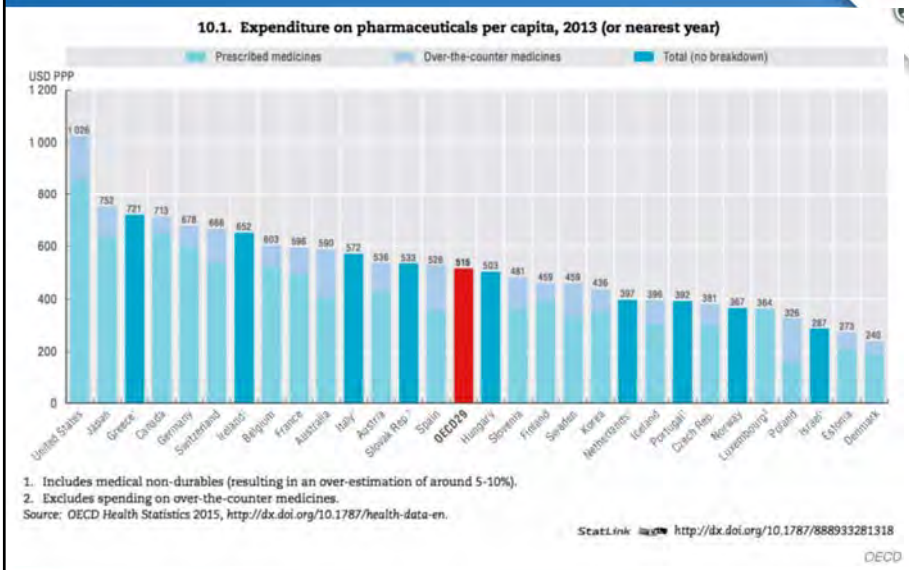
Effect Of Hospital Integration And Market Competitiveness On Hospital Prices



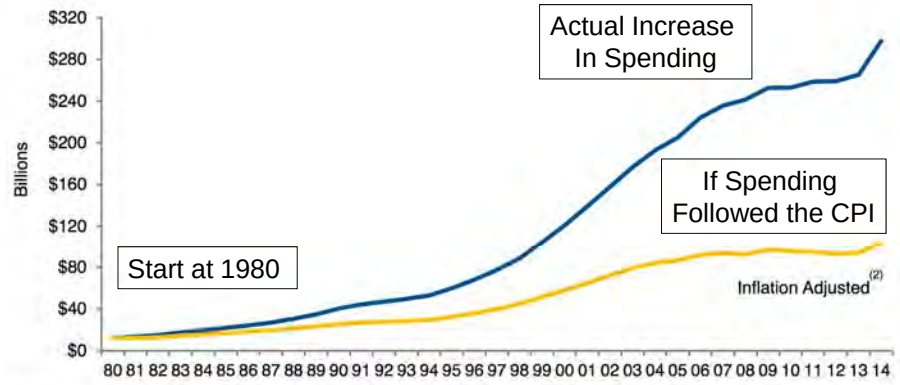
US Costs: Point #2

- A recent driver of higher facility prices is **hospital consolidation**
  - Physicians control costs much more effectively when they are independent

OECD Expenditure on Pharmaceuticals



Total US Prescription Drug Spending



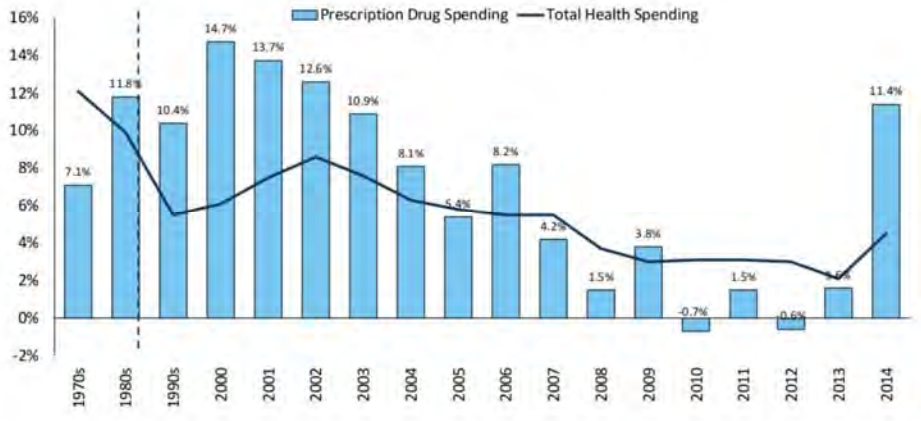
Source: Centers for Medicare & Medicaid Services, Office of the Actuary. Data released December 3, 2015.

(1) CMS completed a benchmark revision in 2009, introducing changes in methods, definitions and source data that are applied to the entire time series (back to 1960). For more information on this revision, see http://www.cms.gov/nationalhealthexpenddata/downloads/benchmark2009.pdf.

(2) Expressed in 1980 dollars; adjusted using the overall Consumer Price Index for All Urban Consumers.

Annual Growth Rate US Prescription Drug Spending

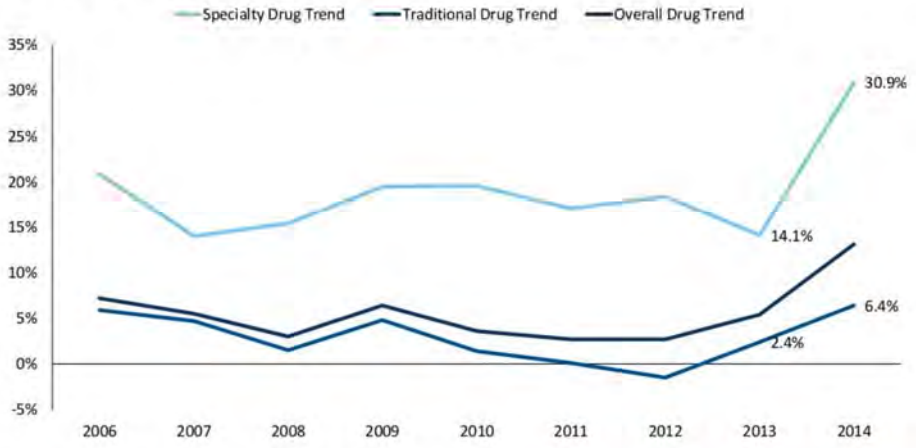
Average annual growth rate of prescription drug spending per capita for 1970's – 1990's; Annual change in actual prescription drug spending per capita 2000 – 2014



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) Historical (1960-2014) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group (Accessed on December 7, 2015)

Costly new specialty drugs are a major driver of increased health spending

Express Scripts drug spending growth trend by therapy class, 2006 -2014



Source: Express Scripts 2014 Drug Trend Report and Year in Review. Available at http://lab.express-scripts.com/drug-trend-report/ and http://lab.express-scripts.com/drug-trend-report/introduction/year-in-review

Drug prices in the United States are 50 percent higher for comparable products; average price gap is nearly 120 percent due to usage patterns

For comparable drugs, US prices are 50 percent higher than in other developed countries . . .

Average price* difference for the same drug
$/pill indexed: EU5*** price = 100

. . . and the use of a more expensive mix of drugs in the United States increases average prices even more

Overall average price*
$/pill indexed: EU5*** price = 100

* Manufacturer price.
** Assumes 15 percent rebates from manufacturers to payers and Pharmacy Benefit Managers (PBMs).
*** Average of the United Kingdom, Germany, Italy, France, and Spain.
Source: IMS Health; McKinsey Global Institute analysis

US Costs: Point #3

- A combination of usage, higher prices, and specialty pharmacy increases has the United States paying more than **double what other countries do for prescription drugs**

Prices Are Too High

Health Care Costs = Utilization x Cost/Unit

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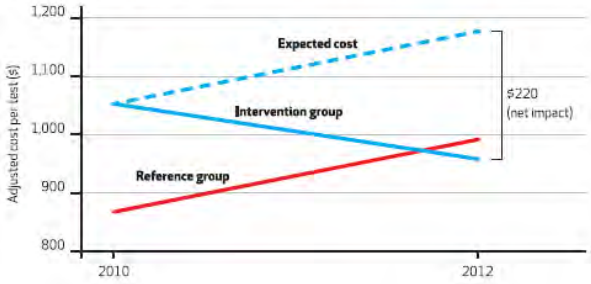
PRICE TRANSPARENCY

By Sze-jung Wu, Gosia Sylwestrzak, Christiane Shah, and Andrea DeVries

Price Transparency For MRIs Increased Use Of Less Costly Providers And Triggered Provider Competition

DOI: 10.1377/hlthaff.2014.0168
HEALTH AFFAIRS 33,
NO. 8 (2014): 1391–1398

Adjusted Cost Per Magnetic Resonance Imaging (MRI) Scan In Intervention And Reference Groups, 2010 And 2012



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The cost of a knee MRI in Dallas ranges from:

A. $300-$600
B. $700-$3,000
C. $500-$800
D. $400-$2,000
E. $600-$1,000

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Costs Differ Dramatically by Location

The Cost of Your Health Care Depends on Where You Park Your Car

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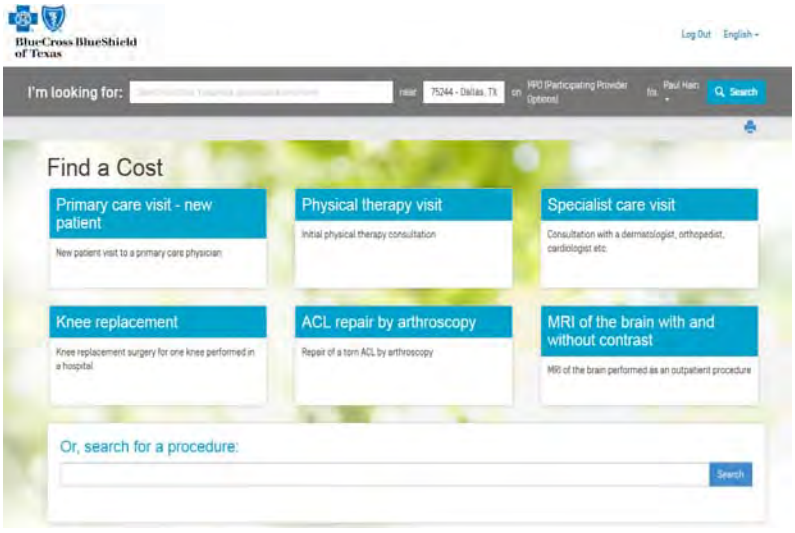
Transparency Tools



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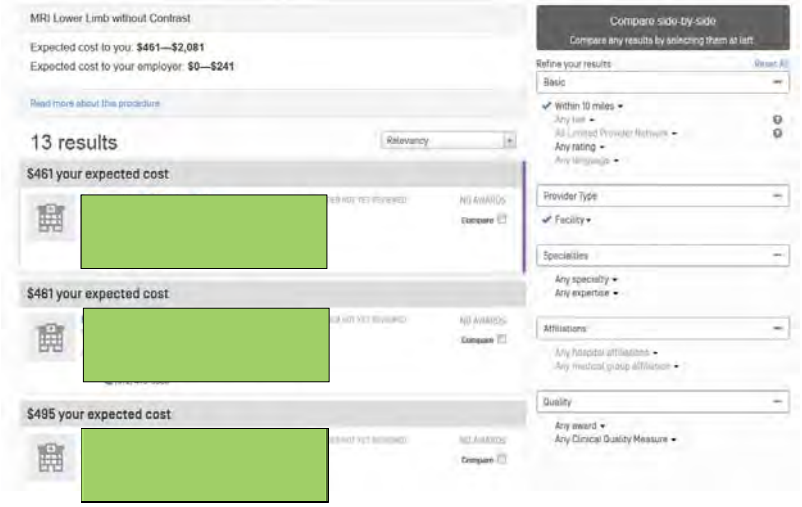
Transparency Tools



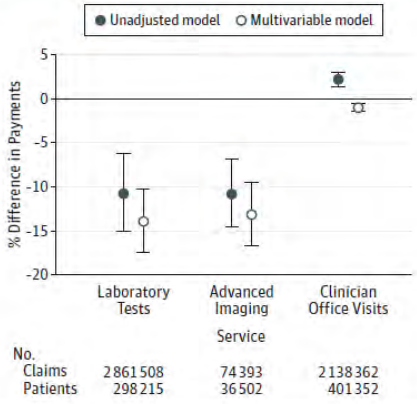
Benefits Value Advisor

Increased focus on assisting employees and their family with health care decision-making to help improve quality of care and achieve cost savings for both employees and employers

Original Investigation

Association Between Availability of Health Service Prices and Payments for These Services

Figure. Difference in Payments Between Searchers and Nonsearchers



JAMA The Journal of the American Medical Association

CDHPs

Change
Member Behavior

11.8%
Medical
PMPY
(approved charges not including Rx)

Based on a 5 year study adjusted for trend and risk, of individual members before and after switching to a CDHP plan

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Summary So Far…

- The primary driver of increased spending in the United States compared to other Developed Countries is **Higher Prices**
- A recent driver of higher facility prices is **hospital consolidation** and fewer independent physicians
- United States pays more than **double what other countries do for prescription drugs**
- **Transparency solutions and creative incentives** may be able to substantially alter cost trajectory

A Bit About Commercial Insurance

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In a recent poll of Americans, what percentage could correctly identify a deductible, copay, coinsurance and out of pocket maximum?

A. 15%
B. 30%
C. 50%
D. 65%

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Consumers Misunderstanding of Health Insurance

Concept	Correct
Deductible	78%
Copay	72%
Coinsurance	34%
Maximum Out of Pocket	55%

n = 202

Percentage of Respondents that Answered All Four Correctly:

14%

Journal of Health Economics 32 (2013) 850–862

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Definitions

- Deductible
  - Amount member pays for health care services before the health insurance begins to pay
- Copay
  - A fixed amount the member pays for a health care service
- Coinsurance
  - Member share of the costs of a health care service, usually as a percentage of the allowed
- Out of Pocket Maximum
  - The most a member will have to pay during a policy period for health care services received

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PPO vs HDHP

Preferred Provider Organization	High Deductible Health Plan
• Can see any doctor in our network • No referral needed to see specialists • All Preventive Care Free	• Can see any doctor in our network • No referral needed to see specialists • All Preventive Care Free
• Low deductible • High monthly premium	• High deductible • Low monthly premium • Includes HSA to help pay for deductible with tax free money

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My deductible is:

A. Less than $500
B. Between $500 and $1,000
C. Between $1,000 and $2,600
D. Over $2,600
E. I came to this lecture to figure that out

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Healthy Employee Only
Each Company is Different!

	PPO 750	HDHP 1500
HSA Employer Contribution	N/A	$750
Deductible	$750	$1,500
Inpt Co-insurance	$4,450	$4,300
total OOP (subject to Max*) =	$4,000	$5,000
Premiums x 12 mo	$1,812	$1,236
Total for year =	**$6,562**	**$6,236**

Scenario: **Totally Healthy Employee, only expense for the year is a $23,000 Knee Replacement**

*OOP Max for PPO is $4,000; for HDHP is $5,000

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Family Coverage
Two Adults, Three Kids

	PPO 1500	HDHP 3000
HSA Employer Contribution	N/A	$1,500
Deductible	Not Met	$3,000
ER Co-insurance/Co-pays	$1,080	$0
Check ups	$0	$0
Sick Visits	$280	$240
Prescription Meds	$720	$720
Total OOP (subject to Max)	$2,080	$3,960
Premiums x 12 months	$5,904	$4,020
Total for year =	**$7,984**	**$6,480**

Scenario: All members get appropriate check ups
one ER visit per child ($1,000 each, happens Jan 1st)
one sick visit per adult, two sick visits per child ($150 per)
one child on asthma meds, adult on hypertension med

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Worst Case Scenario Planning

		PPO 1500	HDHP 3000
Employee Only			
	Max OOP	$4,000	$5,000
	Premiums	$1,812	$1,236
	HSA	NA	$750
	Total	**$5,812**	**$5,486**
Family			
	Max OOP	$8,000	$10,000
	Premiums	$5,904	$4,020
	HSA	NA	$1,500
	Total	**$13,904**	**$12,520**

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Take Home Points for Choosing

- Employer contributions to the HSA often determine which plan is the best for you.
- HSA tax breaks can make HDHP appealing for high earners.
- Worst case scenario risk is mostly determined by how your employer sets the out-of-pocket maximum.

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Preventive Care
Covered at 100% PPO and HDHP

- Check ups
  - Especially important for Children
  - Important for Adults with Chronic Conditions
- Vaccinations
- Screening tests
  - Cholesterol
  - Screening Colonoscopy for over 50 year olds
  - Mammography
  - Pap Smear

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How People Get Health Coverage

Where Do Adults Get Their Insurance?

Type of Health Insurance Coverage in the U.S. Among 18- to 64-Year-Olds

Is your insurance coverage through a current or former employer, a union, Medicare, Medicaid, military or veteran's coverage, or a plan fully paid for by you or a family member? (Primary and secondary insurance combined)

	Q4 2013 %	Q1 2015 %
Current or former employer	44.2	43.3
A plan paid for by self or family member	17.6	21.1
Medicaid	6.9	9.0
Medicare	6.1	7.3
Military/Veteran's	4.6	4.7
A union	2.5	2.6
(Something else)	3.5	4.2
No insurance	20.8	14.5

Source: Gallup-Healthways Well-Being Index

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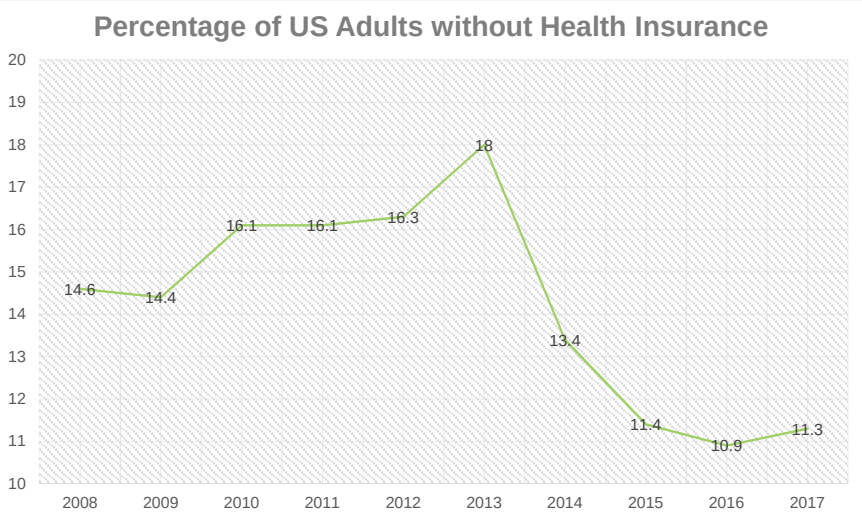
How Many People Are Insured Now?



Source: Gallup-Healthways Well-Being Index

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A Very Limited Review of What Is Happening Right Now

45

Back to Commercial Insurance

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One Other Important Thing to Know:

Most of the Business that Commercial Insurers Do is Not Insurance!

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How Hospital vs Insurance Company Conflicts Start

- Either side can instigate
  - Issue a termination
- Hospitals looking for increased rates
  - High Overhead
  - Market has shifted
  - Offset other losses (like Medicaid)
- Insurance Companies looking to lower trend
  - Pressure from self insured clients to lower total cost of care
  - May feel that other companies get a better deal

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Things that Favor

- The Hospital
  - Niche Services
    - High End Pediatrics
    - Geographic Isolation
  - Halo Effect
    - Great PR team
    - Academic Medical Center
- The Insurance Company
  - High Marketshare
  - Viable 2nd Option
    - Steerage is easy
    - Halo effect small
  - High Hospital Charges
    - "Numbers Don't Lie"

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Important Issues in a Conflict

- Communication
  - With Physicians often favors the Insurance Company
  - With Brokers often favors the Hospital
  - With insurance plan members is volatile
- At 30 days prior to going Out of Network
  - Members must have a communication
    - Often an impetus to settle
- At the drop dead date, things heat up even more
  - Cash flow issues for hospital
  - Out of Network charges for Insurance Company

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Typical Management of High Priced Facilities

- Remove from Network Completely
  - Insurance company decides
  - Or Company decides in a Narrow Network
- Create Tiered Benefits
  - Self Insured corporation decides
- Advance Consumerism
  - Let the patient decide through transparency tool

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More on “Steerage”

- Hospitals will often trade price concession for volume
- Carriers, or individual companies may steer patients to certain facilities for price breaks
- Typical ways:
  - Tiering
    - Covered deductible or all covered
    - Increased company co-insurace (90/10 vs 70/30)
  - Narrow Network
- Universal Out of Pocket limits have decreased the ability to steer…Unless you make a system out of network

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Payment Methodologies

Per Diem	Percent of Charges	DRG (Diagnosis Related Groups)
Hospital gets a set fee per day that the patient is in the hospital (different for floor vs ICU)	Hospital gets a negotiated percent of the billed charges (chargemaster)	Hospital gets a bucket of money based on the diagnosis of each admission
Incentives Admissions: Increase LOS: Increase Costs: Decrease	**Incentives** Admissions: Increase LOS: Increase Costs: Increase	**Incentives** Admissions: Increase LOS: Decrease Costs: Decrease

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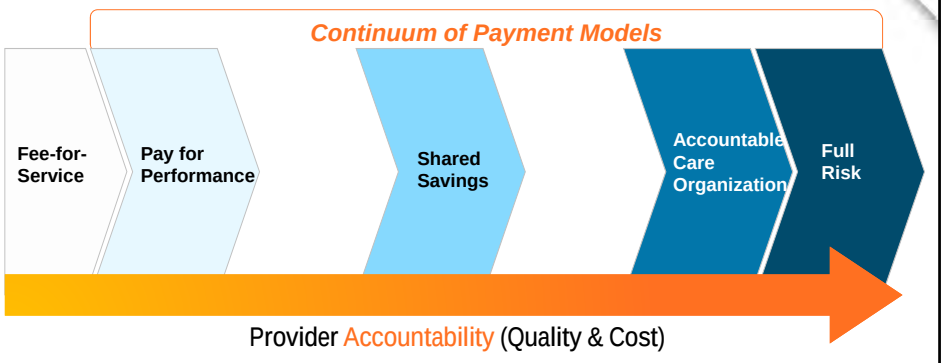
Payment Structures to Align Incentives:



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New Payment Structures

- Pay For Performance (P4P)
  - Negotiate targets for quality, efficiency or both
- Shared Savings
  - Set target goals based on actuarial assessments of populations, group gets a share of the amount of money below the target
- Accountable Care Organization (ACO)
  - Group of physicians/providers/facilities who agree to be responsible for the total care of a population
  - Incentives aligned so that spending less (fewer admissions) results in a gain to the group

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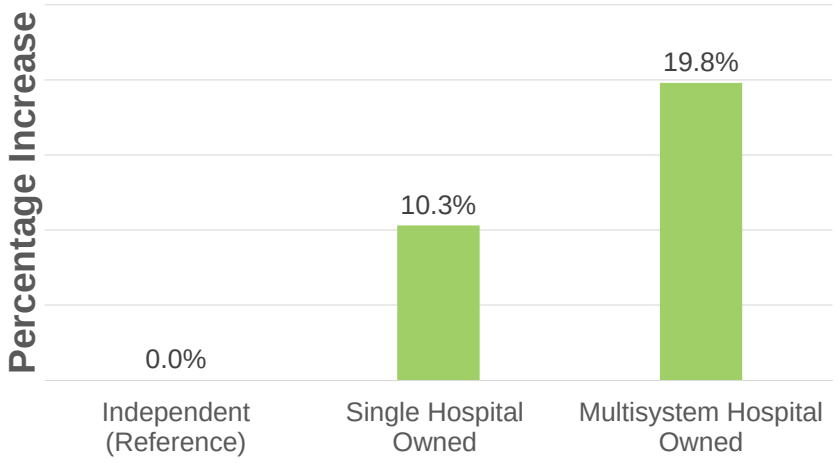
Accountable Care Organizations

- Provider (e.g., hospital or large physician group) agrees to attempt to manage a population of patients and decrease costs while maintaining or improving quality
- If ACO achieves quality benchmarks, it shares in any cost savings
- Private payers attempting to move providers into “ACO-type” contacts
- Not one ACO model

Original Investigation

Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California



JAMA. 2014;312(16):1663-1669. doi:10.1001/jama.2014.14072

Beware of ACOs in Name Only

Hospital A

$2,000 per member per year;
Attracts 500 **XYZ** employees

Total costs = $2,000 x 500 = $1 M

Hospital B

$1,000 per member per year;
Attracts 500 XYZ employees

Total costs = $1,000 x 500 = $0.5 M

New ACO to cut 10% costs

Total Cost
$1.5M

$1.64M

$1,800 per member per year;
Attracts 800 members

Total costs = $1,800 x 800 = $1.44 M

$1,000 per member per year;
Attracts 200 XYZ employees

Total costs = $1,000 x 200 = $0.2 M

Independent Physician ACO

- Hospital ACOs can be double edged
  - "fill the beds" vs "keep them well and out of the hospital"
- Independent Physician ACOs can create well aligned incentives, as the physician and colleagues are responsible for quality of care as well as cost

Take Home Points

- The primary driver of increased spending in the United States compared to other Developed Countries is Higher Prices
- A recent driver of higher facility prices is hospital consolidation and fewer independent physicians
- United States pays more than double what other countries do for prescription drugs
- ACOs can lower the total cost of care, but only if the prices aren't so high that lowering utilization can't overcome the price

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Take Home Points

- Insurance Companies Do Not Like Uncertainty, but there is a lot of it Right Now
- Most People Don't Know Basic Insurance Terms
- High Deductible Plans Can Be Good for You
- Hospitals and Insurance Companies Will Continue to Have Conflicts Until We Are More in Value Based Care
- Transparency Coupled with Incentives is Becoming a Highly Effective Solution to High Prices

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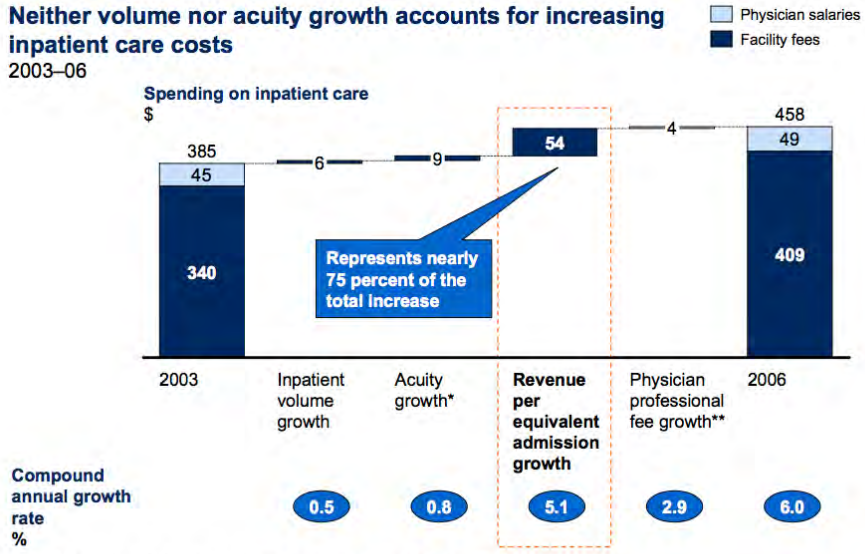
BlueCross BlueShield of Texas

Questions?

Neither volume nor acuity growth accounts for increasing inpatient care costs

2003–06



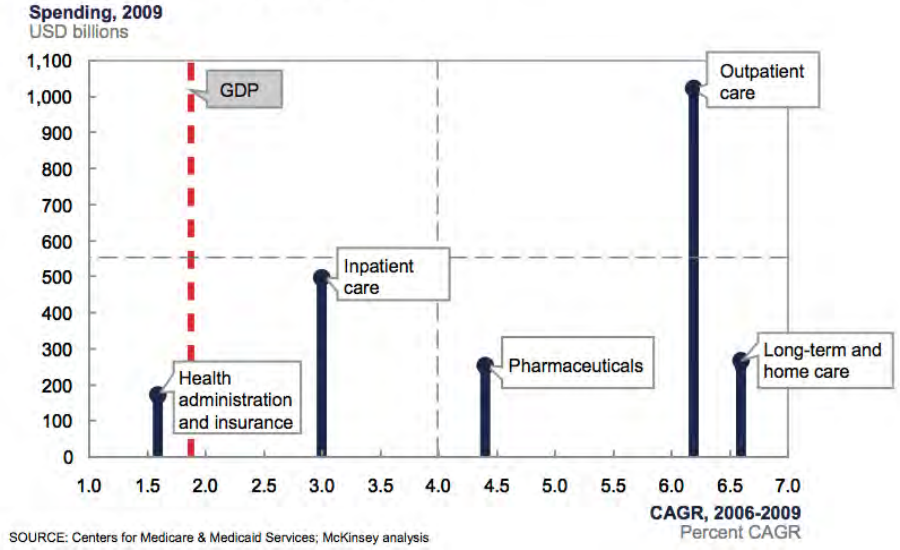
* Acuity growth defined as percent increase in Case Mix Index (CMI).

** Includes payments to physicians for inpatient hospital care for comparability with other OECD countries.

Source: OECD, National Center for Health Statistics (NCHS) National Hospital Ambulatory Medical Care Survey; Medical Group Management Association (MGMA); company reports; McKinsey Global Institute analysis

McKinsey Global Institute

Every spending category grew faster than GDP between 2006-2009 except for health administration and insurance

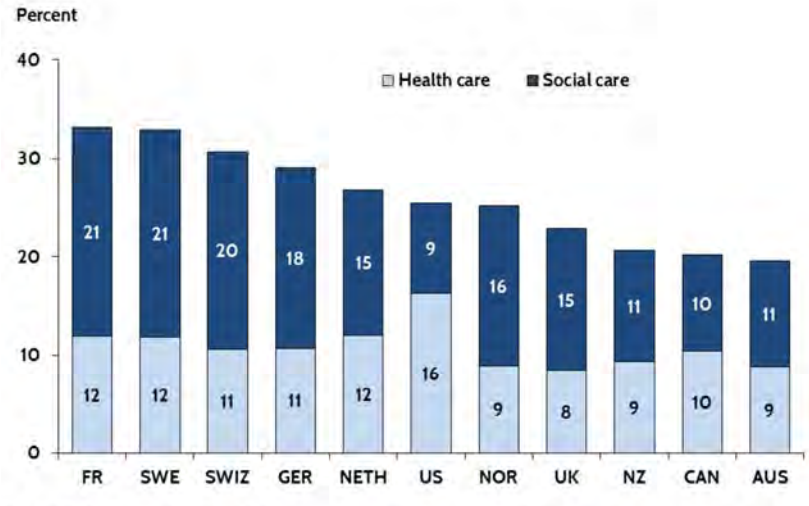


SOURCE: Centers for Medicare & Medicaid Services; McKinsey analysis

ACO goals

- Improve the safety and quality of patient care while lowering costs
- Promote shared accountability across providers
- Increase coordination of care
- Invest in infrastructure and redesigned care services
- Achieve better health and better care at lower costs

Health and Social Spending as a Percentage of GDP



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

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Spending on administration and insurance slowed in every category since 2006, and actually declined for private payers

Growth in spending by source
Percent CAGR[1]

1 Compound annual growth rate
2 This includes the non-Federal component of administrative spending on workers compensation
3 Other federal / state primarily Department of Veterans Affairs and Department of Defense spending
SOURCE: OECD; Centers for Medicare & Medicaid Services; McKinsey analysis

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