Health care's tipping point…will price transparency be the answer?

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ADFM Winter Meeting

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Vizient Research Institute

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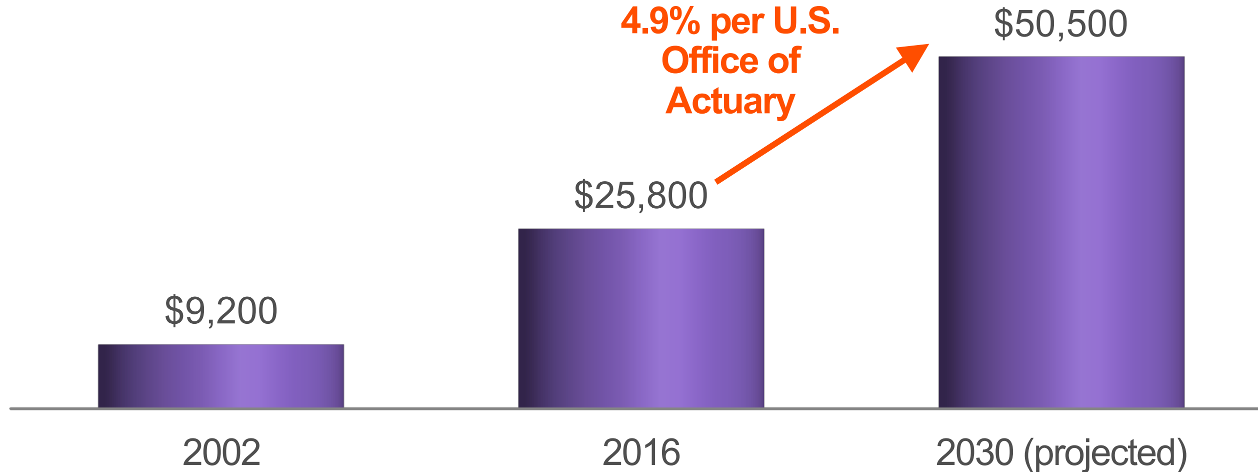
How far to the tipping point?

Average annual health care spending per working household (Insurance premiums and out-of-pocket expenditures)



	2002	2016	2030 (projected)
Median compensation (wages plus health benefits)	$68,600	$105,800	$149,000
Health spending as percentage of compensation	13.4%	24.4%	33.9%

Sources: Girod CS, Weltz SA, Hart SK. Milliman Medical Index, 2016. http://www.milliman.com/uploadedfiles/insight/periodicals/mmi/2016-milliman-medical-index.pdf.; Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2016.

1958

2012

23.1 Days

3.3 Days

Cost = days of median wages

1958

2012

22.7 Days → 3.9 Days

Cost = days of median wages

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1958

8.5 Days

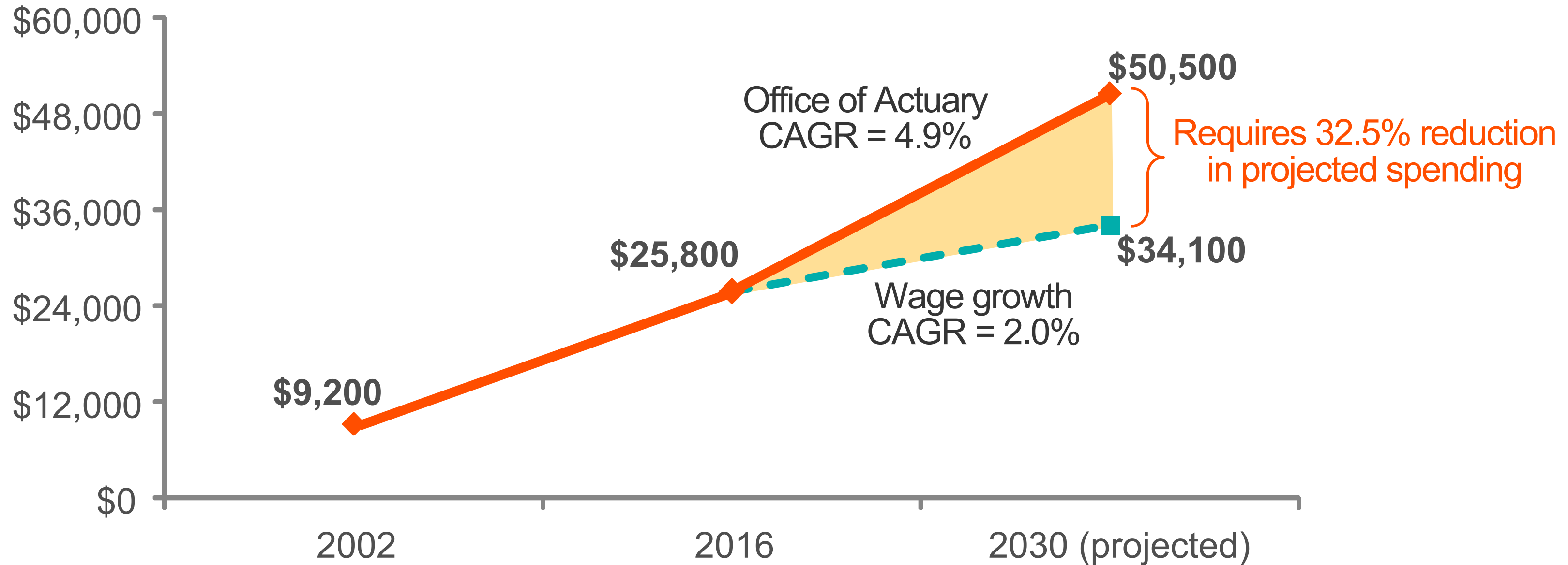
Cost = days of median wages

2012

63.7 Days

Cost = days of median wages

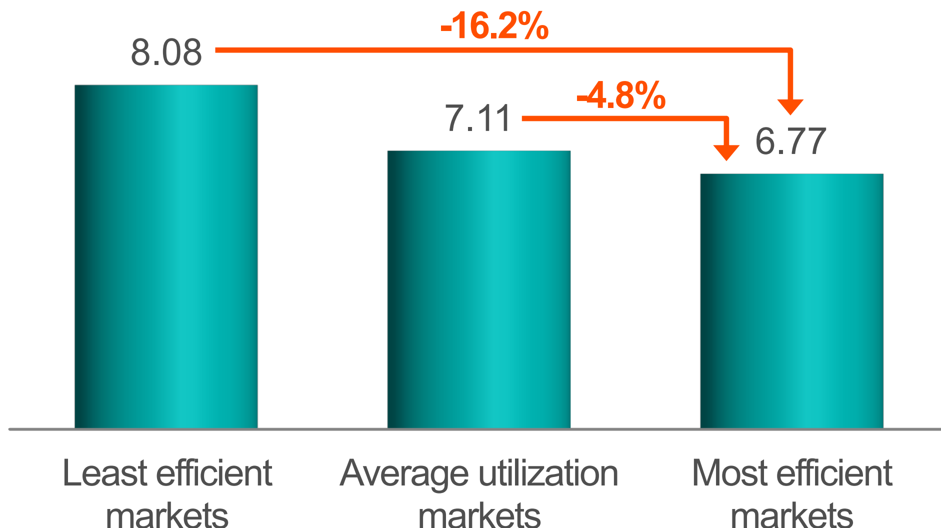
How much can middle America afford for health care?

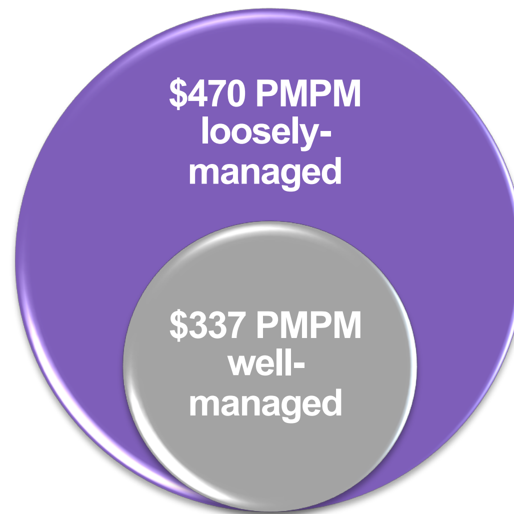


First do no harm: to avoid further erosion of middle class standard of living – not to improve it – requires a reduction of over 30% in projected health care spending vs. Office of Actuary forecast

Source: Girod CS, Weltz SA, Hart SK. Milliman Medical Index, 2016. http://www.milliman.com/uploadedfiles/insight/periodicals/mmi/2016-milliman-medical-index.pdf.; Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2016.

Ten percent waste reduction an ambitious target for actively working population



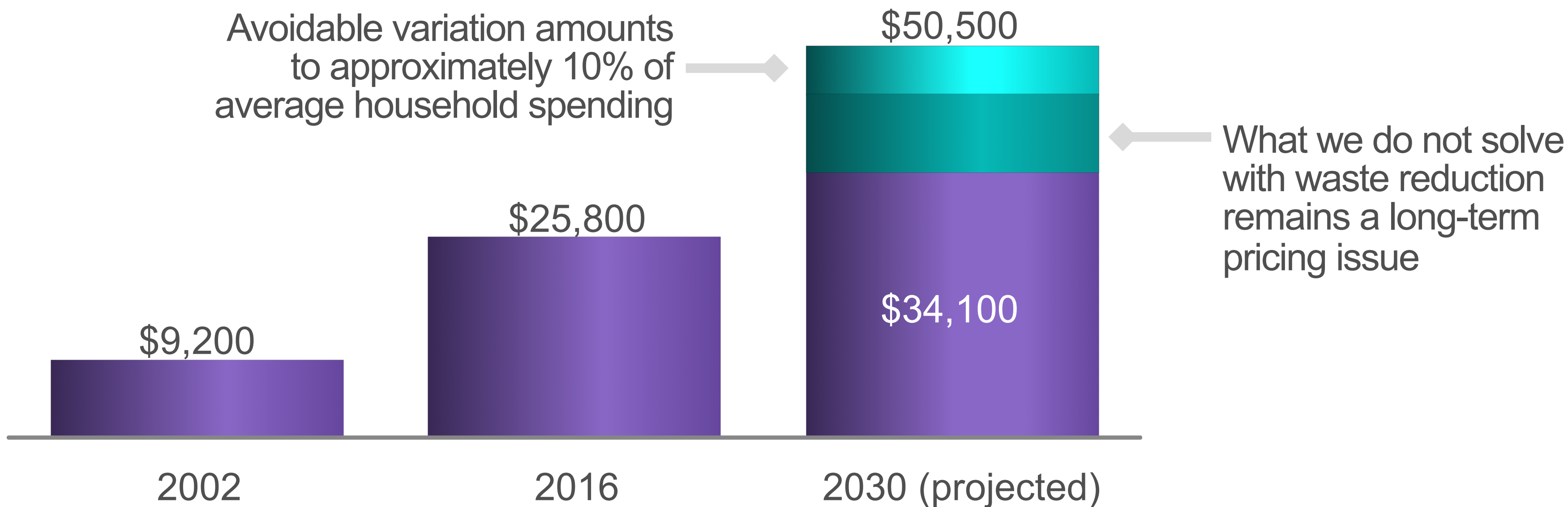


7% ← **Weighted average waste reduction potential in commercially insured population** → 17%

Source: Milliman analysis of commercial claims, 2015.

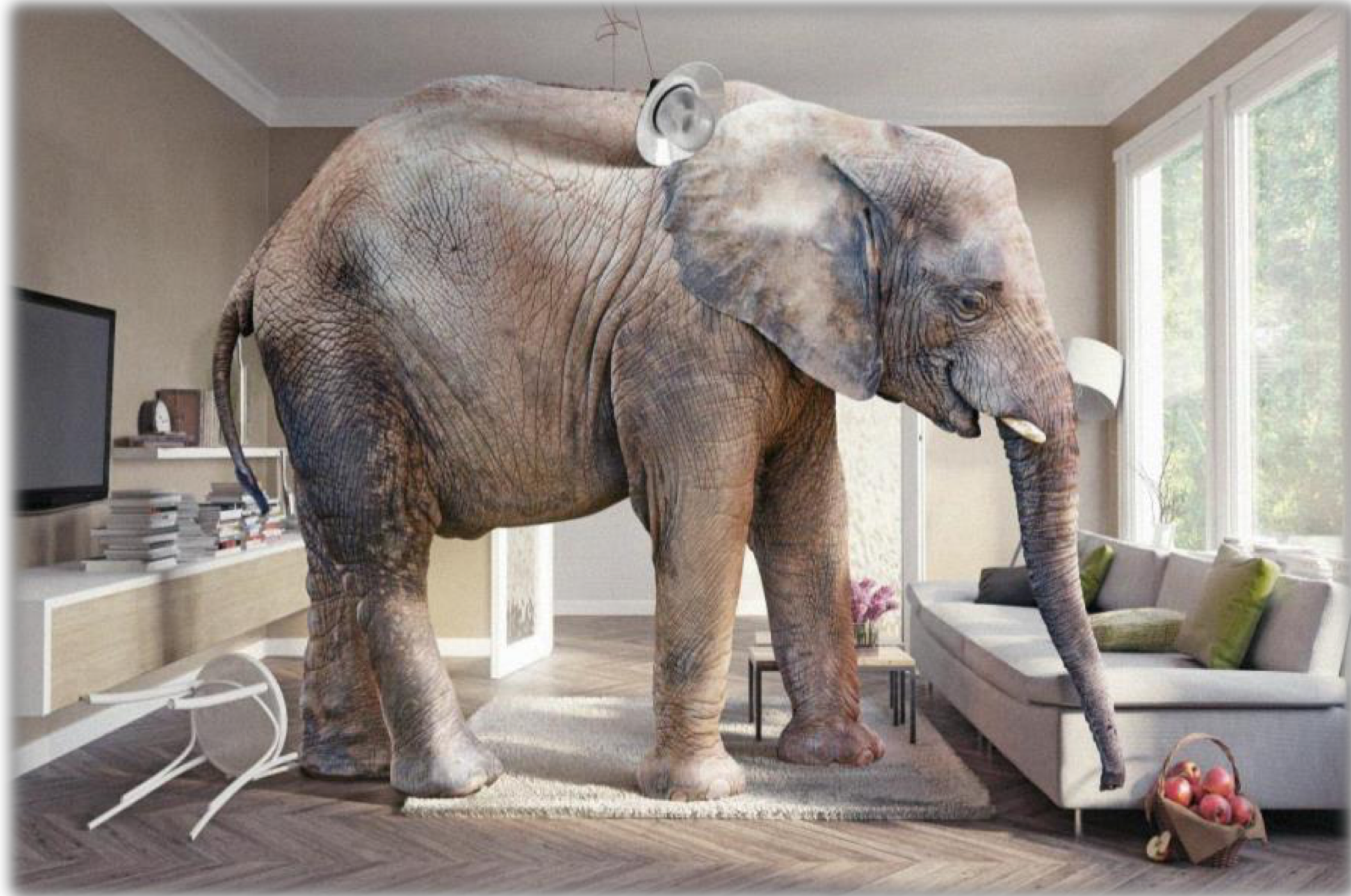
Avoidable utilization only one-third of middle class affordability dilemma

Health care spending per working household (insurance premiums and out-of-pocket)

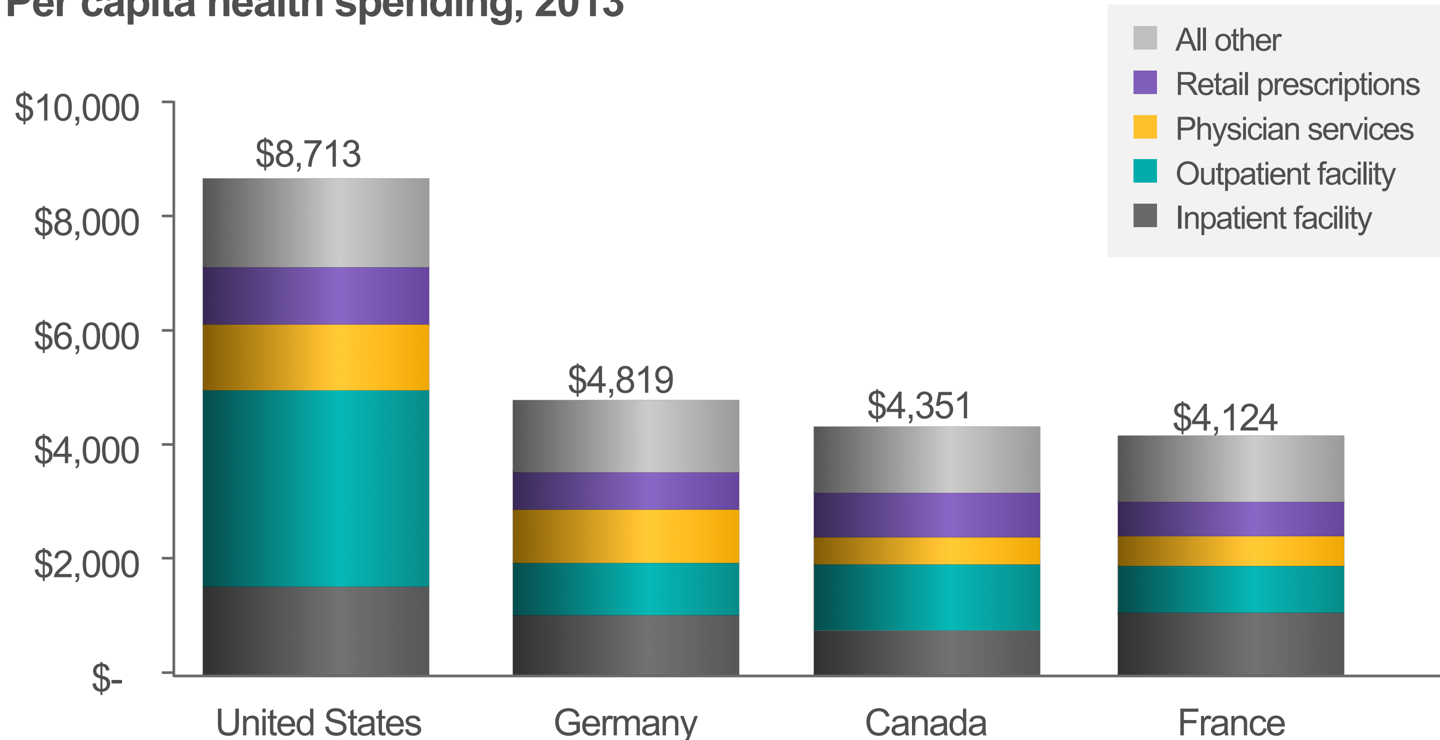


Source: Girod CS, Weltz SA, Hart SK. Milliman Medical Index, 2016. http://www.milliman.com/uploadedfiles/insight/periodicals/mmi/2016-milliman-medical-index.pdf.; Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2016; Milliman analysis of commercial claims, 2015.

Waste reduction not enough…prices are too high

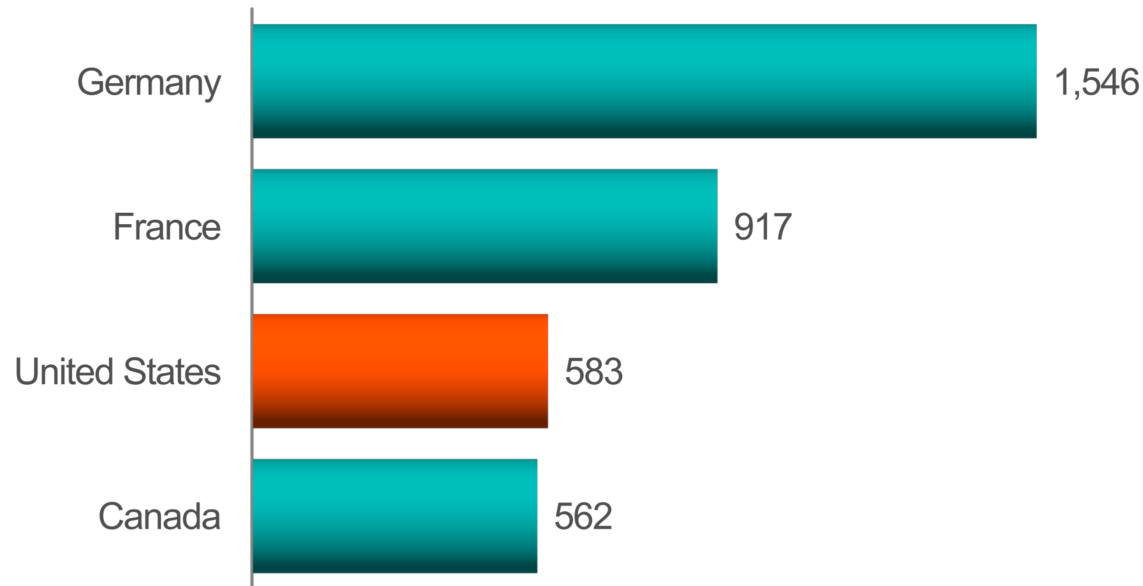


U.S. health spending out of step with OECD peers



Source: Analysis of data from the OECD, 2011-2013: https://data.oecd.org/health.htm and the Medical Group Management Association, 2011: http://www.mgma.com/.

U.S. inpatient utilization low, but spending is high



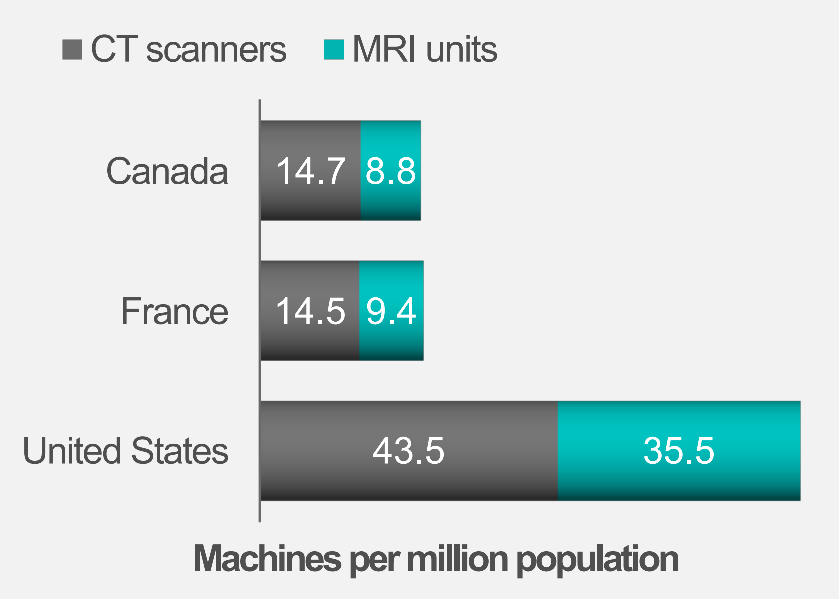
Inpatient cost per 1,000 population (in USD PPP)

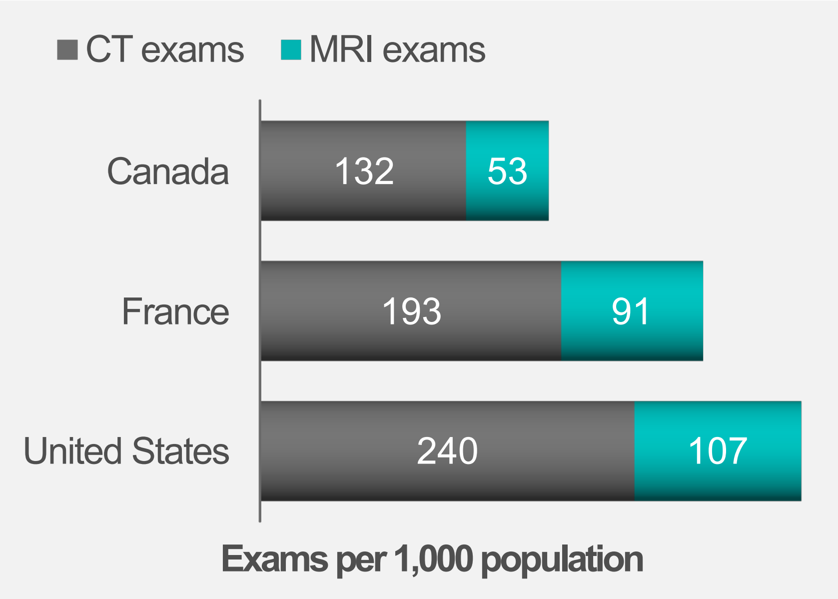
$1.0 million
$1.1 million
$1.6 million
$0.8 million

Average hospital revenue per inpatient day in U.S. = $2,700 compared with $600 to $1,400 in other OECD countries…U.S. commercial prices are even higher

Source: Analysis of data from the OECD, 2011-2013: https://data.oecd.org/health.htm.

Higher imaging capacity in U.S. linked to higher utilization but lower productivity

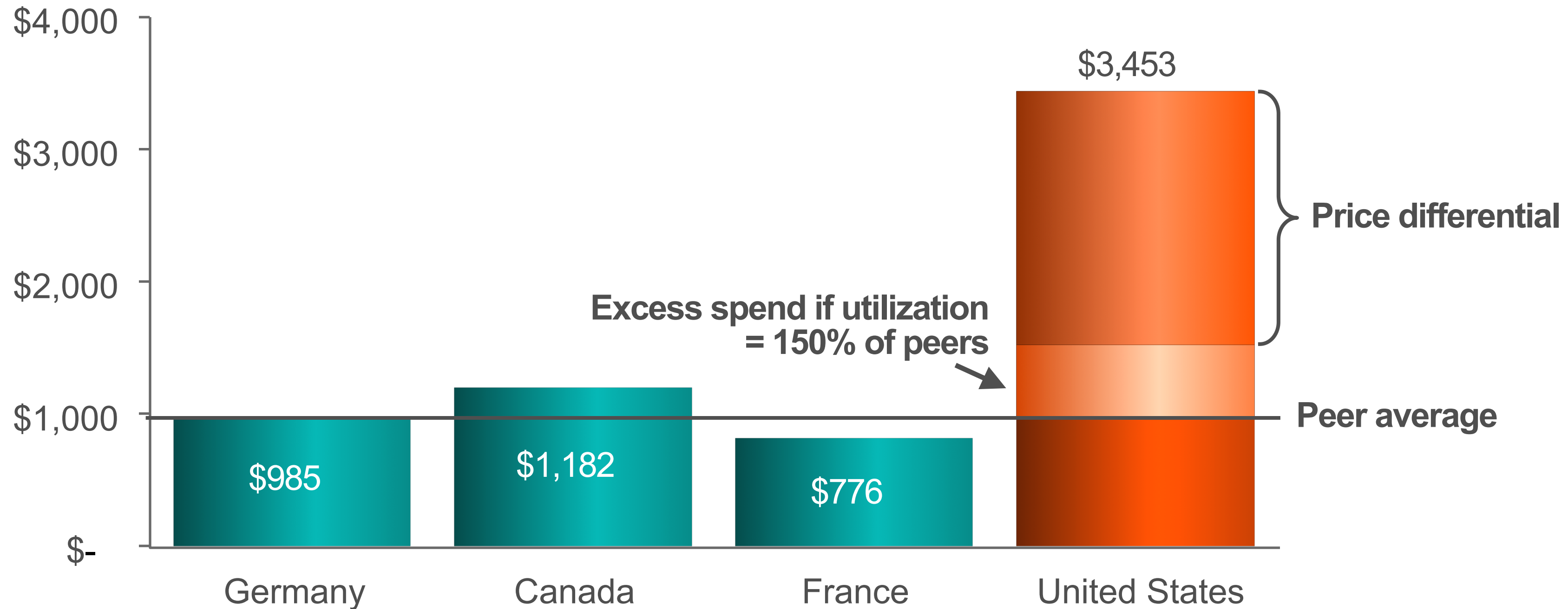




U.S. productivity (exams per machine) is 50% to 60% of Canada and only 30% to 40% of France…higher fixed costs per exam contribute to higher unit prices

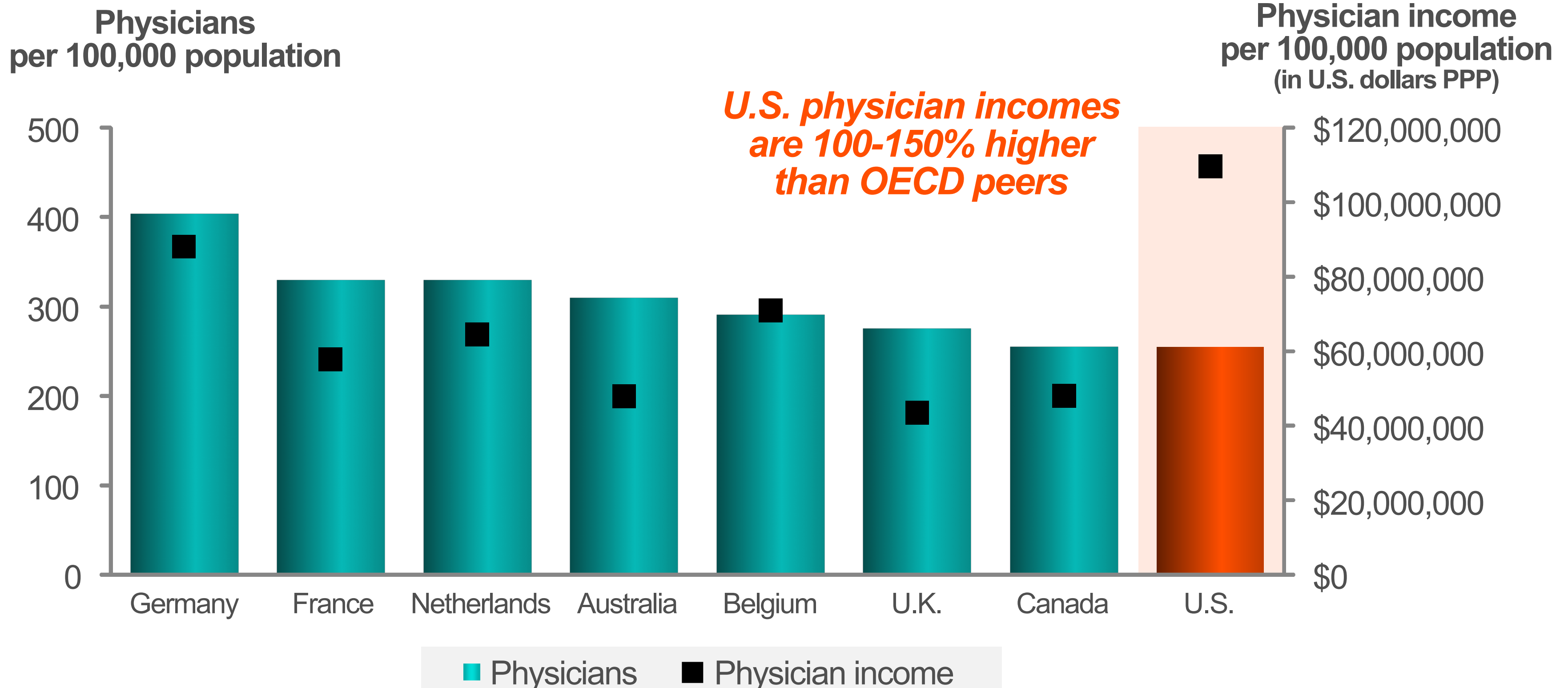
Source: Analysis of data from the OECD, 2013: https://data.oecd.org/health.htm.

Price is major driver of outpatient facility spending gap



Source: Analysis of data from the OECD, 2011-2013: https://data.oecd.org/health.htm and the Medical Group Management Association, 2011: http://www.mgma.com/.

U.S. has lowest physician supply but highest physician spending



Notes: 1. Physician index and salary data include general practitioners and specialists. 2. All data is provided for self-employed physicians with the exception of UK specialist income. 3. Physician income for France, Germany, and U.S. was estimated based on applying a 3.5% CAGR to salaries reported in 2011.
Source: Analysis of data from the OECD, 2011-2013: https://data.oecd.org/health.htm and the Medical Group Management Association, 2011: http://www.mgma.com/.

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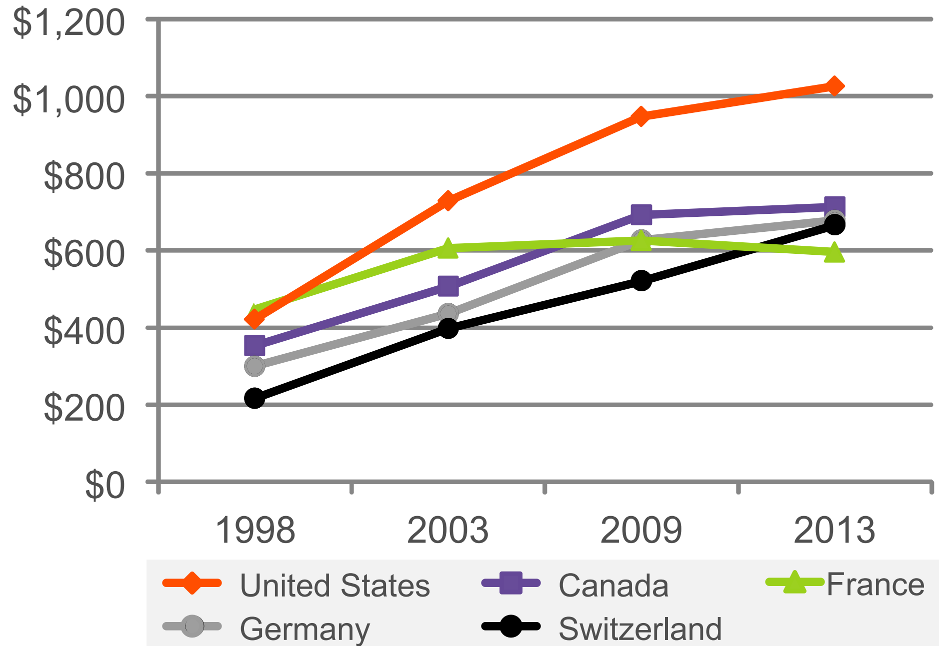
U.S. spending on Rx reflects compound impacts of volume and price

Total expenditure on pharmaceuticals per capita (1998-2013)



- U.S. per capita Rx spending now 40% to 72% higher than OECD comparators
- U.S. writes roughly 50% more prescriptions per capita vs. other western countries
- Manufacturer prices 25% to 100% higher in U.S.
- Launch price per month for new cancer Rx was $100 in 1970, $1,000 in 2000, and $10,000 now

Note: Includes spending on prescription and over-the-counter medications

Sources: OECD Health at A Glance, Expenditure on pharmaceuticals per capita (2001, 2005, 2011, 2015); Kanavos et al. (2013). Higher US Branded Drug Prices And Spending Compared To Other Countries May Stem Partly From Quick Uptake of New Drugs. Health Affairs, 32(4), 753-61; Commonwealth Fund International Health Policy Survey (2013); Peter B. Bach, MD, Memorial Sloan Kettering Cancer Center.

Forty-year-old solutions like swinging a broken hammer

- Hill-Burton and Medicare cost reimbursement led to excess inpatient capacity in the 1970s…managed care plans pounced
- Reducing hospitalizations worked in 1988 – not the answer in 2018
- Avoidable utilization (inpatient and outpatient) accounts for only 1/3 of the middle class affordability crisis…the lion's share is price
- Preoccupation with risk transfer to providers takes eye off the ball; doing less will help, but paying less is shortest route
- Rube Goldberg payment schemes take decades to implement and almost always have unintended consequences
- No chance middle class can afford health care by 2030 unless unit prices fall significantly

Think tanks, insurers, and billionaires can't be wrong…price transparency has to work

"Is everybody ready to have real pricing power brought to bear in a way that could destabilize the health-care sector? It means upsetting a lot of apple carts."

– RWJ Foundation

"The Blue Cross Rewards[SM] program is our way of highlighting provider location options for group members while helping them save, earn monetary incentives and maintain their health."

– BCBS of Michigan

Goal = produce "simplified, high quality and transparent healthcare at a reasonable cost."

– Amazon/Berkshire/JP Morgan health venture, January 30, 2018 press release

Sources: 1. Robert Wood Johnson Foundation (RWJ). How price transparency can control the cost of health care. RWJ website. Published March 1, 2016. 2. New Blue Cross Blue Shield of Michigan rewards program encourages employer group members to 'shop' for affordable care [press release]. Detroit, MI: MI Blues Perspectives; September 18, 2018. 3. Amazon, Berkshire Hathaway and JPMorgan Chase & Co. to partner on U.S. employee healthcare [press release]. Seattle, WA: Business Wire; January 30, 2018.

The logic

- Classic economic theory says demand falls as prices rise
- High deductible health plans (HDHPs) designed to trigger price shopping as financial responsibility shifted to patients
- Three-fold variation in prices common within metro markets for “shoppable” services
- Price transparency tools readily available – insurer tools even calculate patient share using deductibles/copays
- Middle class households struggling to make ends meet; they will jump at opportunity to save money

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Vizient study of health care consumer behavior

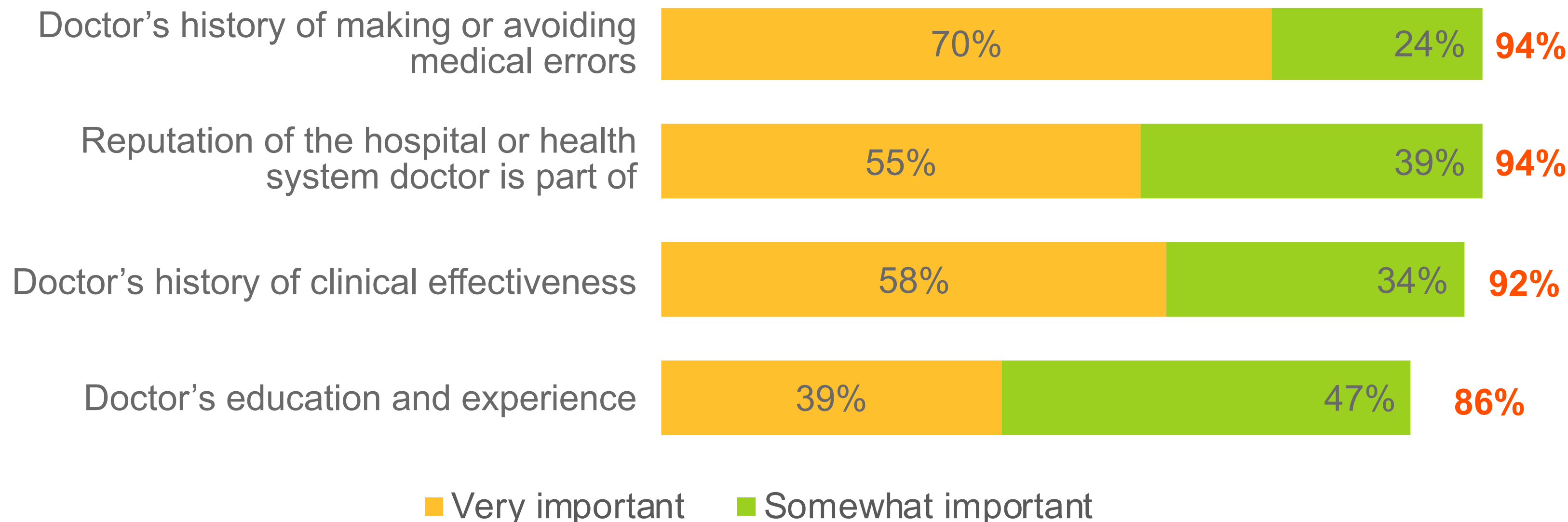
at the UNIVERSITY of CHICAGO

- What do consumers think about when choosing a doctor or hospital? What matters most?
- How do patients evaluate quality? Will they pay more for better?
- Do consumers shop on price? Does price transparency work?

National survey, one-on-one in-depth interviews, and 5 focus groups of commercially insured middle class consumers

Conceptually, consumers say clinical quality is important when selecting a new doctor

Percentage of respondents rating each factor as important when picking a new doctor or specialist.



Source: NORC at the University of Chicago Survey, June 2018.

But cost and convenience tip scales when forced to decide

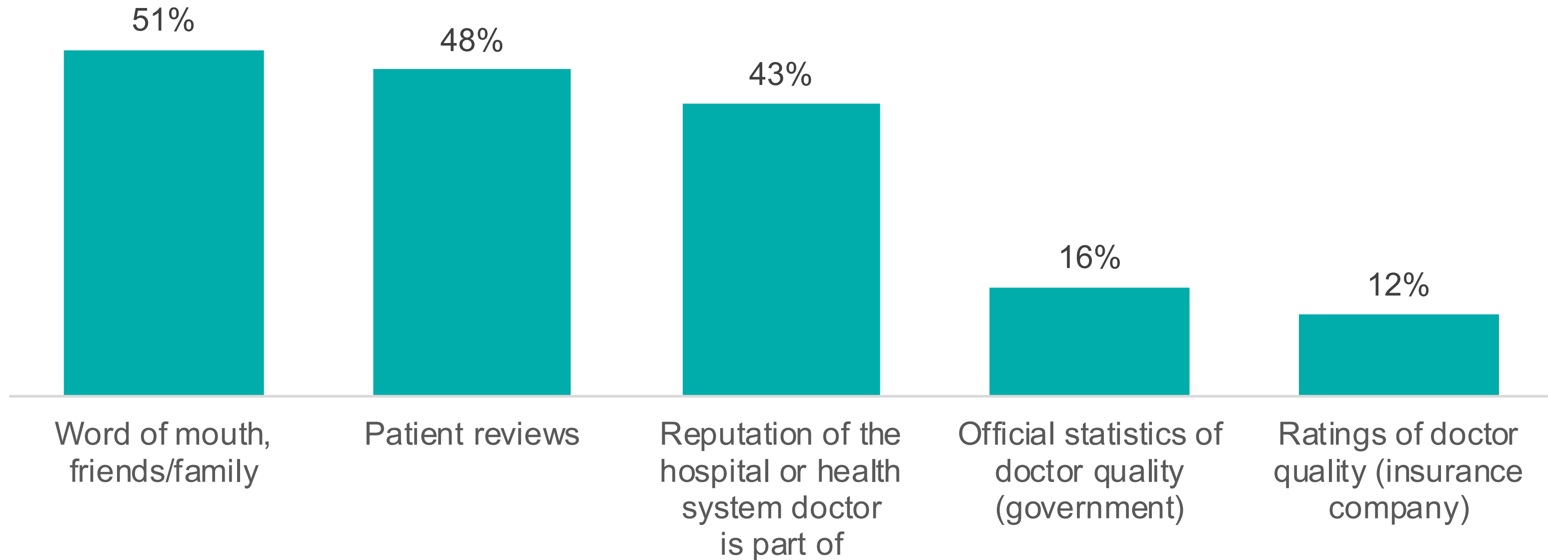
Which three factors usually end up being most important when picking a new doctor or specialist?

	Share selected
Out-of-pocket costs	44%
How quickly you can get an appointment	41%
Whether doctor is part of a hospital or health system used for other health care	37%
Proximity of doctor's location to your home or work place	36%
Doctor's history of clinical effectiveness	26%
Reputation of the hospital or health system the doctor is part of	24%
Doctor's history of making or avoiding medical errors	23%
Details about doctor's education and experience	18%

Source: NORC at the University of Chicago Survey, June 2018.

Patient reviews and reputation three times as important as quantifiable indicators of clinical quality

Which 3 types of information are the best indicators of whether you can expect higher or lower quality care from a doctor or specialist?



Source: NORC at the University of Chicago Survey, June 2018.

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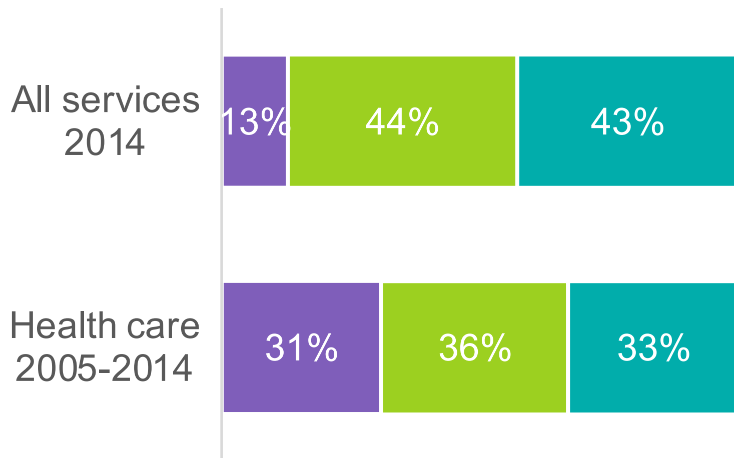
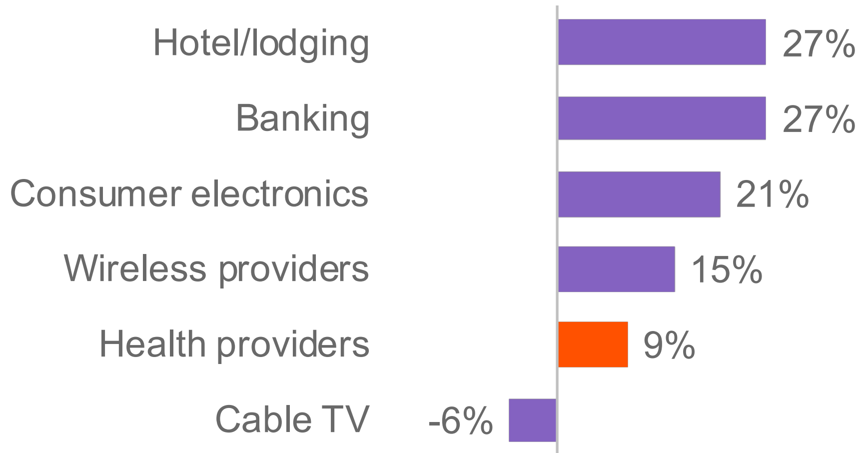
Consumer reviews more polarized in health care…has implications in "reputation" market





2/3 of health care reviews either 1 or 5 stars
Health providers over twice as likely to receive 1-star review vs. other industries

Sources: 1. Ranard BL, et.al. Yelp reviews of hospital care can supplement and inform traditional surveys of the patient experience of care. *Health Affairs*. 2016; 35(4): 697-705. 2. Pilon A. Yelp reviews are getting more positive AND more negative. Small Business Trends website. Published January 24, 2015. 3. Stephan J-P, MacCracken L. Think your patients are loyal? Think again. Accenture website. Published 2016.

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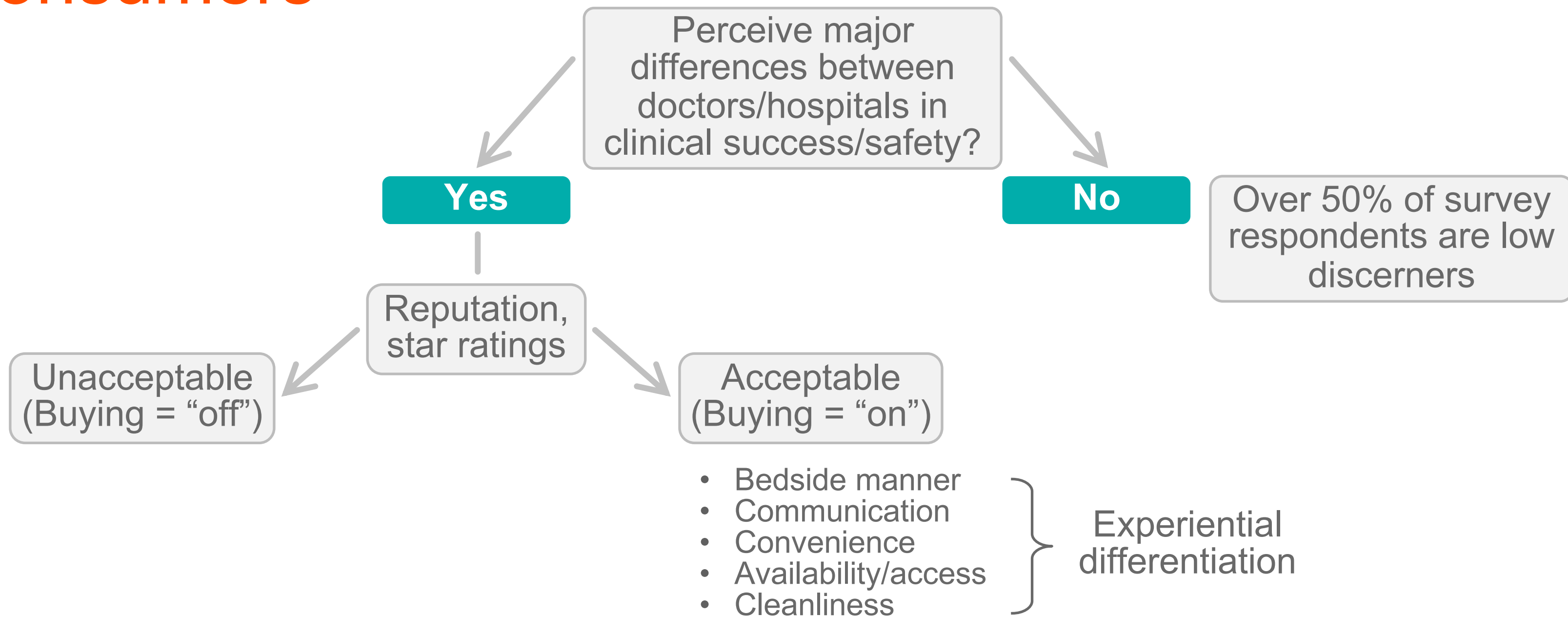
Quality is a binary variable to most health care consumers



For the typical consumer, highly polarized ratings – based on experiential factors not incremental clinical quality – create an "on/off" switch

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How discerning is the typical consumer?

Think about the extent to which doctors provide services based on the most up-to-date scientific knowledge. Do you think there would be major differences or no differences depending on which doctor you choose to go to?

Source: NORC at the University of Chicago Survey, June 2018.

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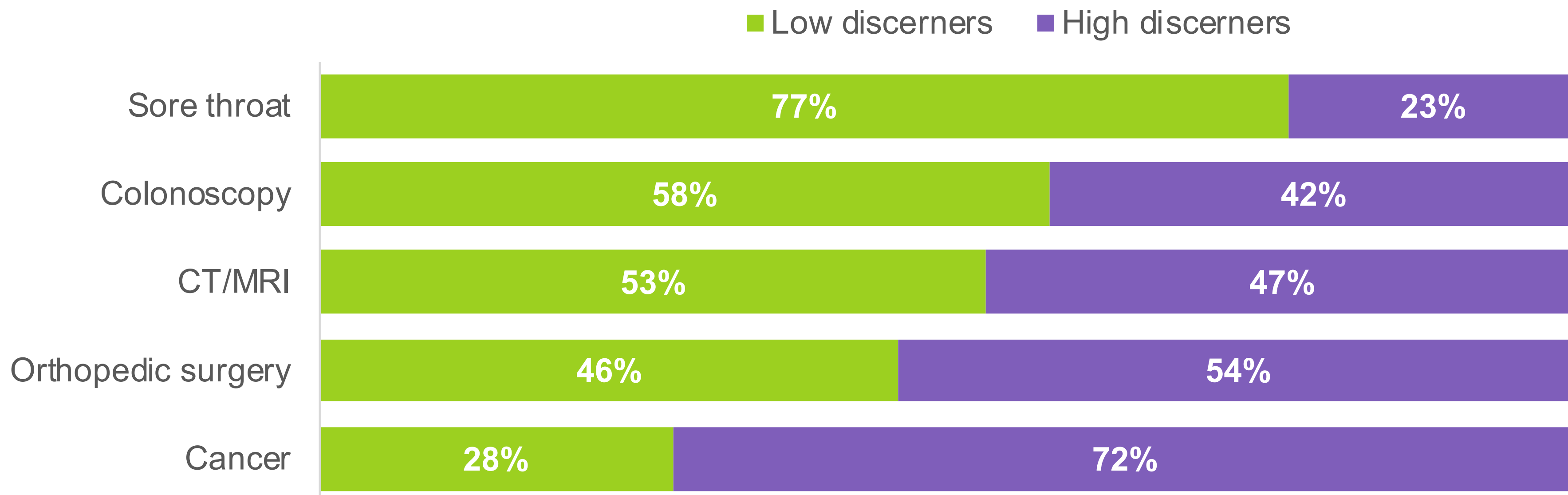
Discernment steadily grows as severity increases



"For brain surgery, I want #1; for knee surgery, I could go with #6 or #7"

"It all comes down to what's wrong with you…for minor stuff, I'd go to Walgreens"

Source: NORC at the University of Chicago Survey June 2018 and Focus Groups August 2018.

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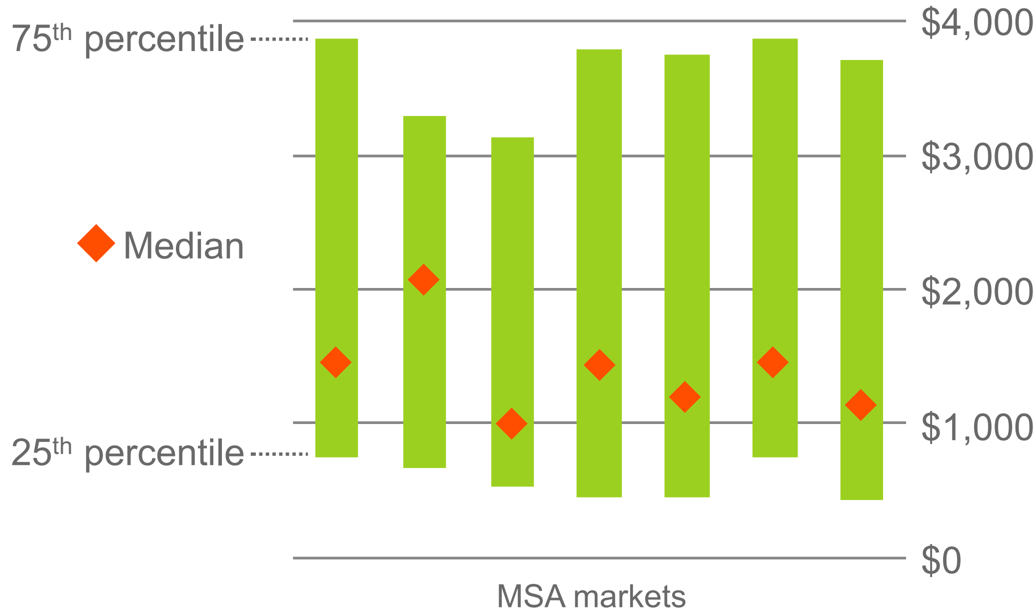
What consumers say they'll do not always what they end up doing

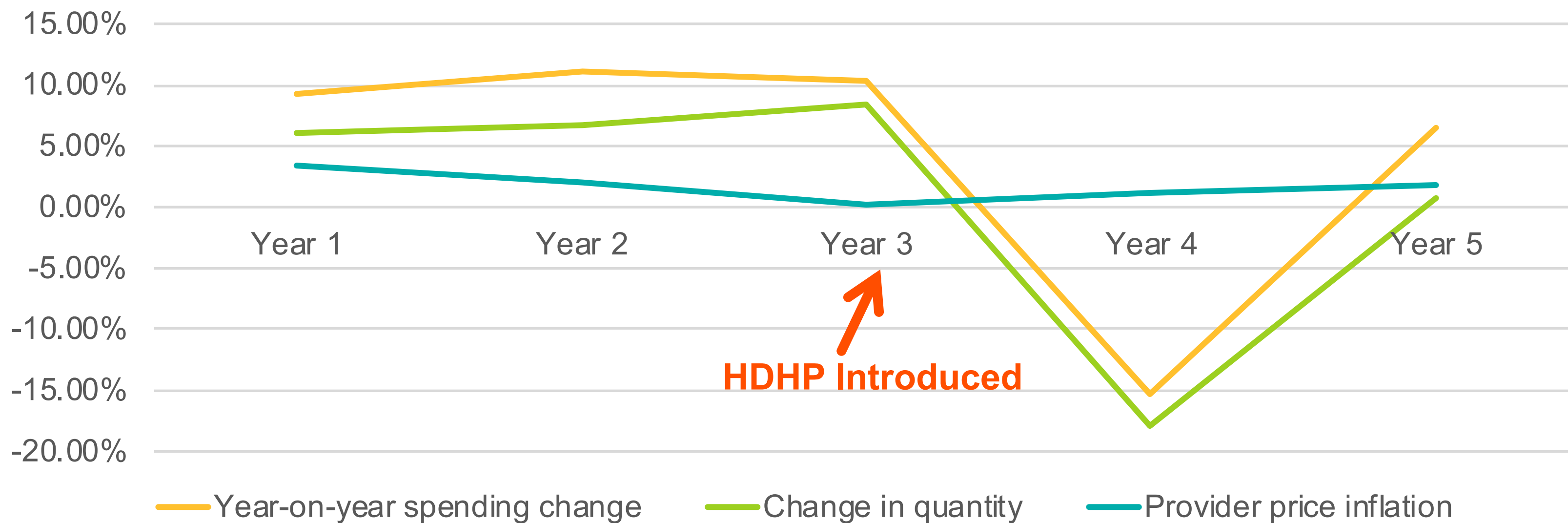
Intra-market price variation, non-emergent CT/MRI



Source: Milliman analysis of commercial claims, 2016.

Despite consumers saying they would opt for lower-priced imaging, as many patients are paying $3,000 to $4,000 for CT/MRI as those who are paying only hundreds in the same market

High deductibles trigger shut down, not shopping



"…plans appear to reduce health care costs by decreasing the use of both appropriate (such as cancer screening) and inappropriate (such as low-severity ED visits) health services" - Health Affairs, 2017

Source: Brot-Goldberg ZC, et al. What does a deductible do? The impact of cost-sharing on health care prices, quantities, and spending dynamics. *The Quarterly Journal of Economics.* 2017;132(3): 1261–1318.

Two consumer archetypes, neither one scared

"Avoider"		"Acclimated"
Younger	Age	Older
Healthier	Health status	Complex/chronic illness
Occasionally/rarely	Hit deductible/OOP?	Regularly
Low/moderate	Annual spending	High
Low/moderate	Health savvy	High
Low	Price savvy	High
No	Worried?	No

"When I'm in open enrollment, I don't think about having cancer or a heart attack…I worry about paying for tuition or vacation."

"I track my progress toward my out-of-pocket throughout the year…it doesn't take much to hit my deductible."

Source: NORC at the University of Chicago Focus Groups, August 2018.

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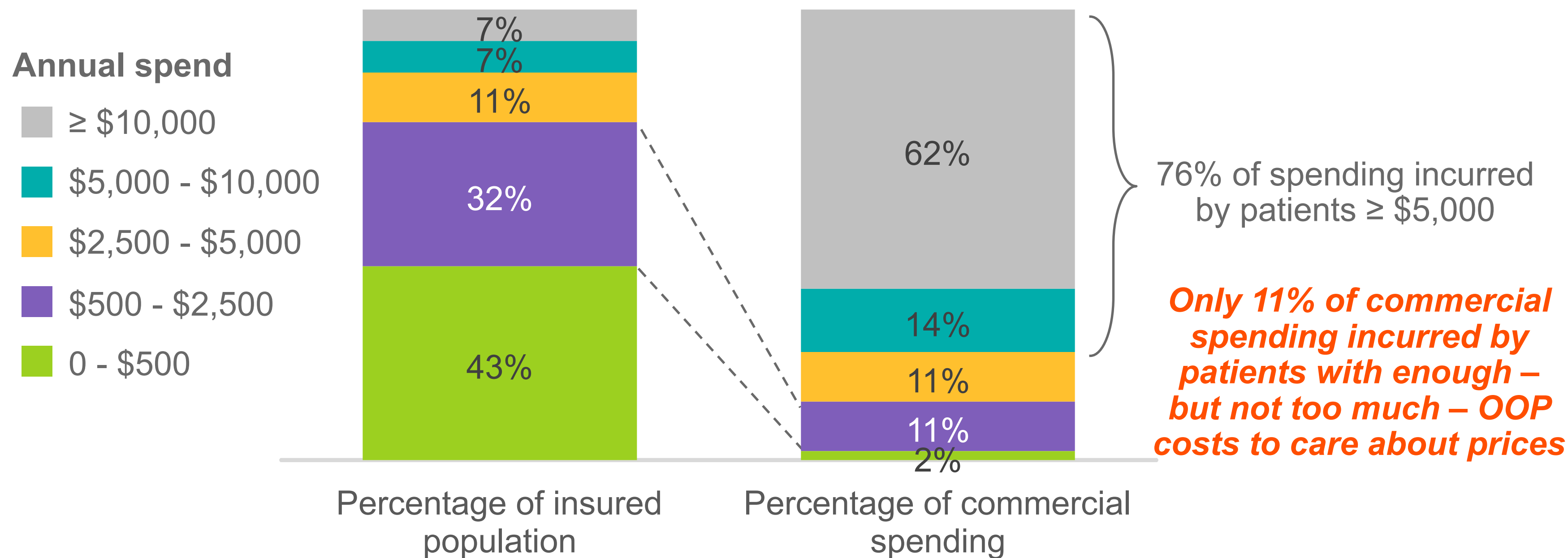
In the end, price-sensitive spending much too small to generate hoped-for system savings



Source: Analysis of data from Agency for Healthcare Research and Quality Medical Expenditure Panel Survey (MEPS), 2014. MEPS website.

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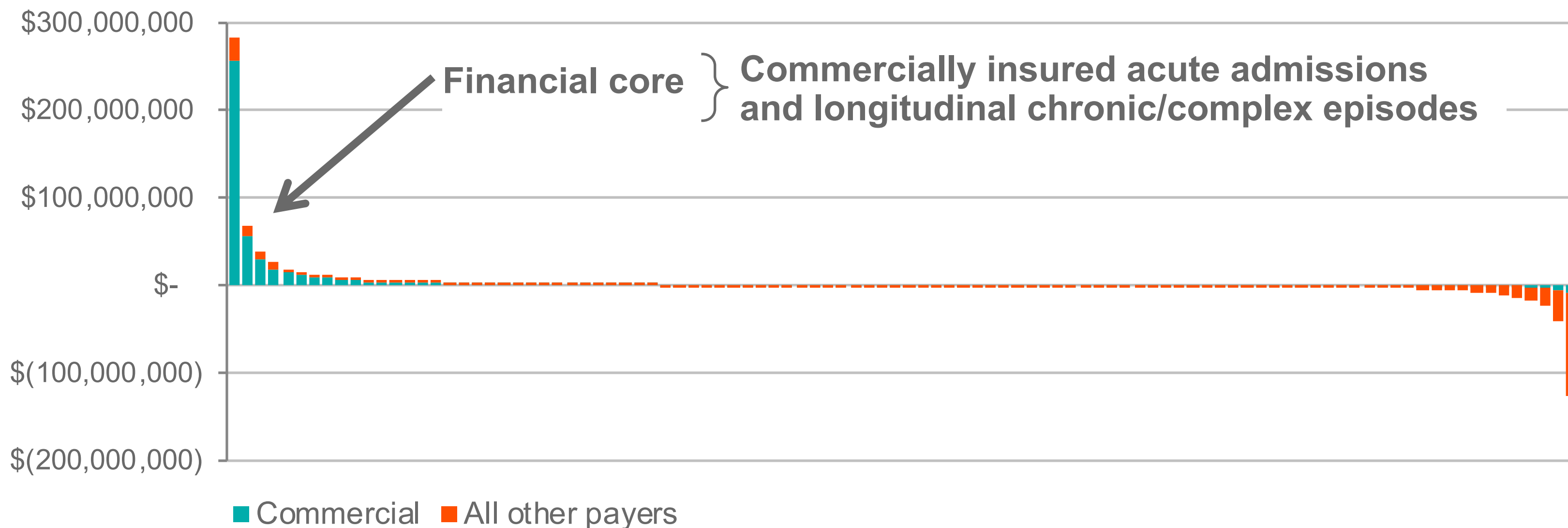
Blast from the past…remember the "S-curve"

Distribution of operating margin by patient percentile



For the typical tertiary/quaternary hospital, 234% of total operating margin comes from only 10% of all patients… for smaller hospitals, 3x total margin arises from most profitable 10%

Source: Analysis of member hospital data in the Vizient Clinical Data Base and Vizient Financial Data Base, 2017.

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Very little price sensitivity for “core” patients

- 50% of core patients incur ≥ $20,000 in allowed hospital charges
- 80% incur allowed hospital charges ≥ $10,000
- 100% incur ≥ $5,000 in allowed hospital charges
- HDHP deductible threshold = $1,350
- 40% of core patients meet HDHP deductible threshold again within 2 years
- Average operating margin/core patient = $20,484

Source: Analysis of member hospital data in the Vizient Clinical Data Base and Vizient Financial Data Base, 2015-2017.

What consumers want…and don’t want

What fell flat with focus groups:

- Amazon-like pricing tool to shop for services
- Extended term, interest-free payment plans offered by hospitals

What tested well with focus groups:

Partial relief from deductibles and OOP limits in exchange for loyalty to single health system

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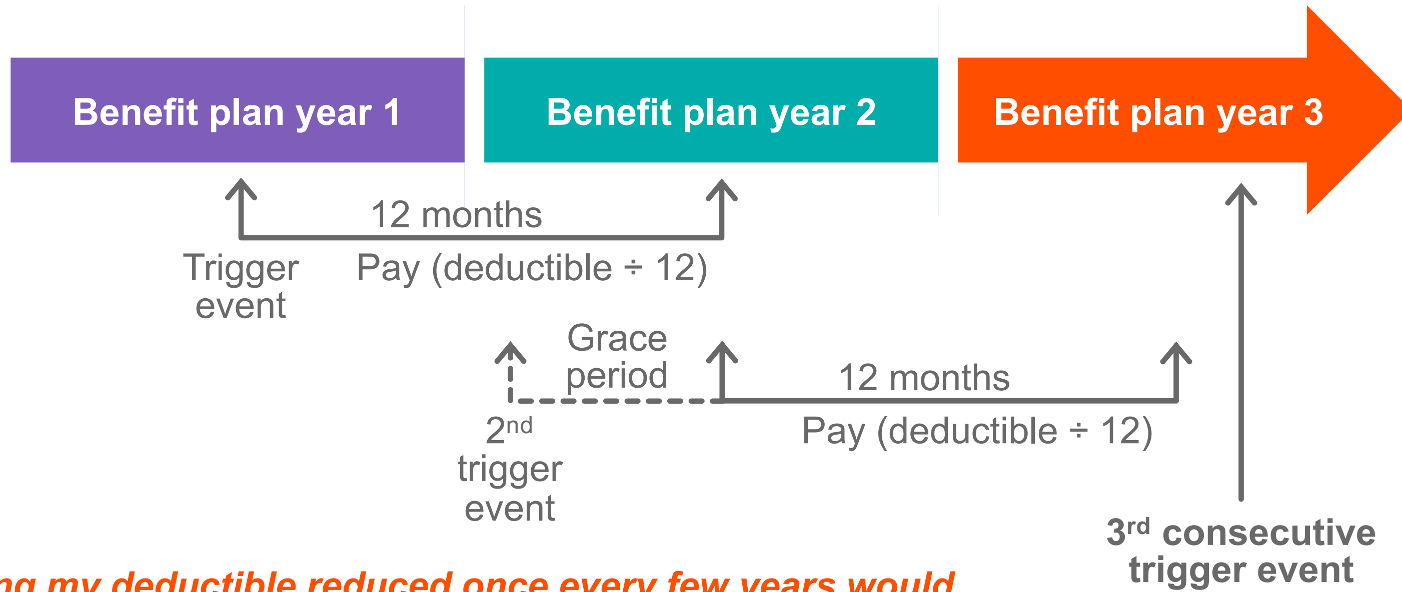
A different tack: target the “acclimated core”

- Design affinity/loyalty programs focused on complex/chronic patients – the “acclimated core”
- Best bet = work with local payers/employers to preempt objections to patient incentives
- Reduce or waive deductible for patients with targeted complex/chronic conditions when services rendered by health system with comprehensive services
- Reduce care fragmentation, lower costs > benefit incentives
- Radical shift from ACO concept – focuses on treating sickest population cohort, not wellness measures for healthy majority
- Incentives directed to provider’s most valuable patients, with genuine savings potential to sponsoring payers

A straw man: “third year free”



3rd consecutive deductible is forgiven

“Having my deductible reduced once every few years would be good because I have a long-term condition. For me personally, it helps out. I definitely agree with it. I like the idea of staying within the system.”

- Focus group participant, Vizient/NORC at the University of Chicago study of consumer behaviors

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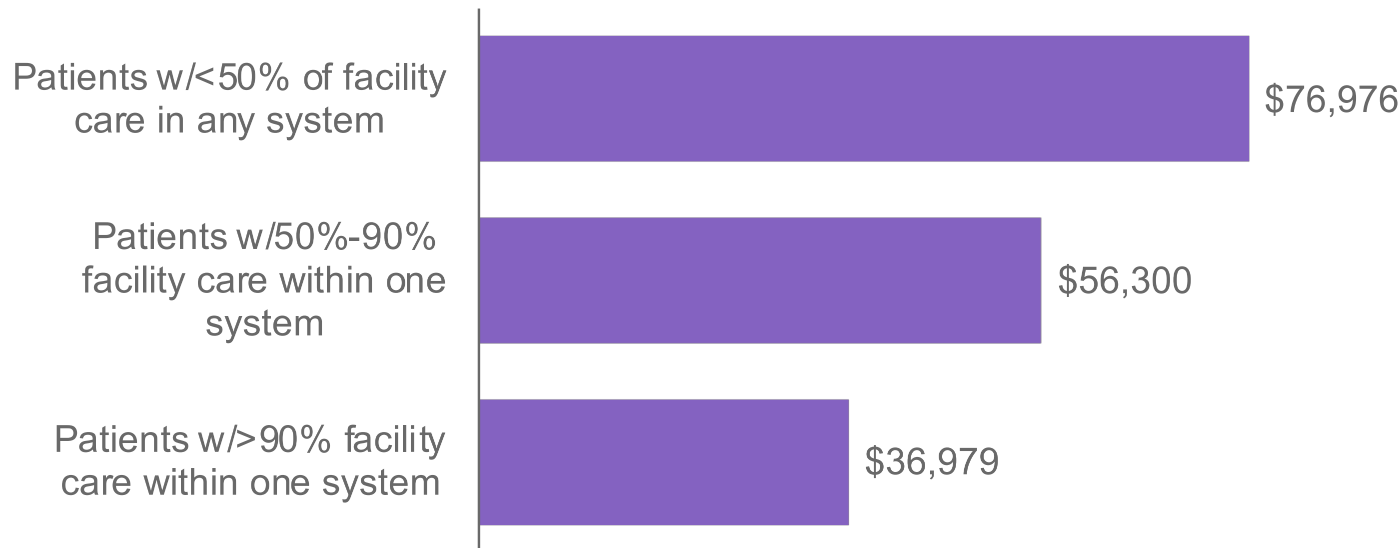
The pitch to payers: reduce fragmentation, save money

Average 3-year episode spend, advanced chronic illness (Medicare claims as proof of concept proxy)



Source: Vizient Research Institute analysis of Medicare claims, 2014-2016.

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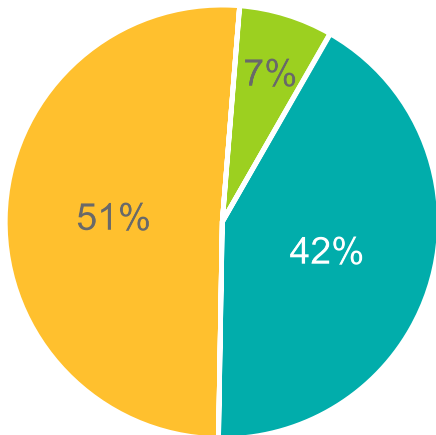
Waiving third consecutive deductible has big ROI if Medicare experience indicative

Assumption: Medicare experience directionally similar to commercial chronic cohort



Distribution of Medicare patients with advanced chronic illness as proxy

- Receive > 90% of facility care from one health system
- Receive 50-90% of facility care from one health system
- Receive < 50% of facility care from one health system

- No savings on 51% of chronic cohort already tightly aligned with single health system
- 34% savings on 42% of cohort loosely aligned with one system
- 52% savings on 7% of cohort highly fragmented currently
- Weighted average savings = 18% across chronic illness cohort
- $18,650 savings per patient over 3-year period

If $1,500 deductible waived once every 3 years for advanced chronic disease, payer ROI would be 12:1 across entire beneficiary cohort

Source: Vizient Research Institute analysis of Medicare claims, 2014-2016, and the Vizient Financial Data Base, 2015-2017.

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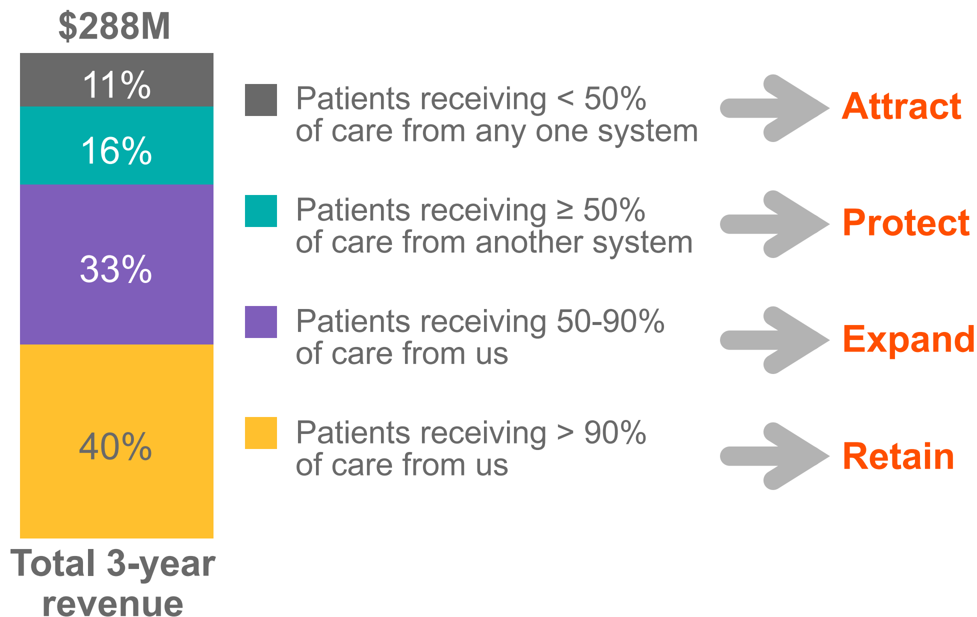
What if we absorb the deductible waiver?

Commercially insured patients with advanced chronic illness who incur ≥ $1,500 at our health system for 3 consecutive years



- Waiving $1,500 deductible once in 3 years → $5.25M in foregone revenue
- Effective discount on $288M is 1.8%
- Benefit targeted at “acclimated core” patients

Source: Vizient Research Institute analysis of Medicare claims, 2014-2016, and Vizient Financial Data Base, 2015-2017.

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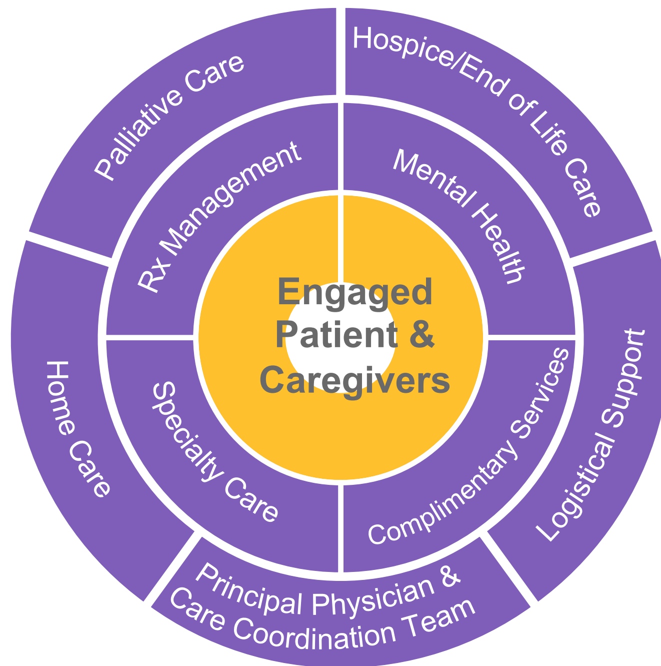
Targeting core incentives higher yield/lower cost alternative to blanket discounts

Spot market discounts		Targeted deductible incentives
Avoiders	Beneficiaries	Acclimated core
Low – patients unaware at time of service	Visibility	High – focus on deductibles/OOP
Minimal	Goodwill/loyalty	Significant
Transient	Duration	Longitudinal
Increases	Fragmentation	Decreases
$30 to $40 million	Foregone revenue	$4 to $5 million
12% to 29% of annual operating margin	Cost to health system	1% to 3% of annual operating margin

Sources: 1. Analysis of member hospital data in the Vizient Clinical Data Base, 2017, and Vizient Financial Data Base, 2015-2017. 2. Milliman analysis of commercial claims, 2016.

Transforming the care approach for the chronically ill

Chronic Disease Medical Home Model



Depending on the site and patient population, each service may be:
(a) provided through a core chronic/complex care team, or
(b) supported by the care team and delivered through external health system providers or community resources.

**Complimentary services may include physical therapy, occupational therapy, rehab services, hospice/end of life care, palliative care, home care, etc.*

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The yin…

- Intuition and classical economic theory were wrong – high deductibles cause patients to shut down, not shop
- Quality to consumers is binary, not linear – they won't pay more for "better" unless scared
- Prices too high to matter; consumers avoid until unable, then quickly over their heads
- Two consumer archetypes – avoiders and acclimated – and neither is particularly worried about OOP exposure
- Hospitals viewed as benevolent creditors – consumer anxiety much lower than expected
- Don't panic – wrong time to discount, right time for caution
- Core patients – our most profitable – almost sure to hit OOP limit; unit prices irrelevant
- Unconventional thinking – focus on acclimated core not avoider majority – best path forward

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…And the yang

- Health care unaffordable for many today, on path to overwhelm middle class households
- Utilization/waste reduction only soften the blow – prices unsustainably high
- Price transparency intuitively appealing but will not have impact hoped for
- Short-term reprieve for providers, long-term dilemma for America
- Future without external price controls difficult to envision

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