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Agenda

- Health Care Costs
  - Background
  - Drivers of health care costs
  - Provisions in the Affordable Care Act (ACA)
- American Academy of Actuaries' Health Cost / Quality of Care Initiative (HC/QC)
  - Series of issue briefs
  - Partnership with the Health Care Cost Institute
- New Models of Care Delivery
- Questions

Health Care Costs

American Academy of Actuaries

Background

- Total health care spending in the U.S. reached $2.8 billion in 2012 – a 3.7 percent increase from 2011
  - Since 2009, cost growth has slowed to levels not seen for decades
- The share of the gross domestic product (GDP) devoted to health care spending was 17.2 percent in 2012
  - One out of every six dollars goes to health care
- Notwithstanding the recent slowdown in health spending growth, it is crucial to explore options that could help sustain that slowdown and further reduce cost growth.

Drivers of Health Care Costs

- Most drivers of health care costs can be broken down into two categories:
  - Those that increase the use of services
  - Those that increase the price paid for services
- Drivers that increase the use of services
  - Payment structures that reward volume, not value
  - Medical technology advances
  - Lifestyle choices
  - Lower out-of-pocket costs

Drivers of Health Care Costs

- Drivers that increase the price paid for services
  - Broader versus narrow provider networks
  - Primary care shortages
  - Provider consolidation
- Various approaches are being explored in attempt to lower both the cost and utilization of medical services, including:
  - Comparative effectiveness research
  - Value-based insurance design
  - PCMHs and ACOs
  - Wellness and disease management programs

Health Care Costs and the ACA

- ACA included some provisions to address health care costs, but there is more to do to address cost growth
- ACA provisions to:
  - Promote wellness and prevention
  - Encourage new payment and delivery system initiatives
  - Facilitate comparative-effectiveness research and adoption of best practices
  - Improve health care provider workforce training and development

Academy Health Cost / Quality of Care (HC/QC) Initiative

- Academy's Health Practice Council created a work group to examine cost growth and explore options to address that growth
- This is the beginning of a long-term initiative
- Subgroups have been developing foundational papers on:
  - New models of care delivery
  - Payment system reform
  - Medicare and Medicaid design and delivery system reform
  - Disease management and prevention
- We will continue to build on the work and information included in this first series of papers

Partnership with HCCI

- The Academy recently formed a partnership with the Health Care Cost Institute (HCCI)
- HCCI is an independent, non-partisan research non-profit
  - Collects data from large insurers with goal of creating a national claims database with information on health care utilization and costs
  - Promotes research on the drivers of health care costs
- Access to the data HCCI has collected will help the Academy enhance its work on costs as part of its public policy efforts

New Models of Care Delivery

Background

- Models Of Care Delivery
  - Open Systems
  - Patient Centered Medical Homes (PCMH)
  - Accountable Care Organizations (ACO)
  - Staff Model HMO
- Patient Care Coordination Continuum

These models vary from uncoordinated to more patient-focused coordination. Note that each model may have different levels of care coordination within them as well.

Introduction

- Delivery system reform is focused on:
  - Increasing quality/efficiency of health care delivery
  - Addressing cost of health care
- The models of care delivery discussed today represent the full spectrum of redesigns and provide reasonable actuarial context
- The future may bring more changes to health care delivery models, including those not yet developed

Open System Model

- Patients access medical care through individual providers
  - Specialists and facility care may require referrals
- Open system model has evolved into a network model (preferred provider organization-PPO)
- Network model more prevalent form of open system model
- Historically, open system model formed core of health care delivery
- Typically, reimburses providers on fee-for-service (FFS) basis
- It is fragmented; often lacks coordination among providers and can foster duplication of services

Patient Centered Medical Homes

- Focuses on creating strong relations between practice staff, patient and provider, and relies substantively on clinical systems
  - Includes focus on quality, patient centeredness, organized IT and data reporting/analysis, practice organization, and payment/reimbursement methodology (payment based on per member per month (PMPM) instead of FFS basis)
- Well suited to higher-risk patients (such as those with chronic conditions or economically disadvantaged)

Accountable Care Organizations

- Comprised of providers that work together to provide cost-efficient, quality care for members
- Providers often have financial incentives based on efficiency and quality of care targets
- Many ACOs are open network
- The Affordable Care Act (ACA) included some provisions to encourage the development of ACOs:
  - Centers for Medicare and Medicaid Services (CMS) created the Medicare Shared Savings Program (more than 200 ACOs participate)
  - CMS also created the Pioneer ACO program with 32 unique ACOs

Accountable Care Organizations (cont.)

- ACO providers have varying degrees of risk
  - Shared savings, with bonus-only methods, typically reimburse the provider on a FFS basis and later pay a bonus
  - Shared savings can include sharing of losses based on the agreed upon targets
  - Global capitation payments provide significant financial incentives, but also risk, to providers

Staff Model HMO

- Closed-panel system whereby physicians are generally employees of the HMO
- Employs providers that perform services for the members enrolled in the HMO
- Goal of this type of health care system is to increase quality of care and reduce cost of care through efficiencies in delivery and management of patient-focused care

Actuarial Components for Care Delivery Models

- Setting budgets and appropriate care coordination fees
- Measuring results
- Evaluating risks and reinsurance
- Evaluating credibility
- Reporting and monitoring of results
- Effect on utilization
- Effect on costs
- Networks of provider
- Evaluating quality incentives

Care Delivery Enhancers

- New strategies have emerged to further enhance care delivery. They can be part of any successful delivery model:
  - Telemedicine is the use of telecommunication and IT options to provide care from a distance; improves access to medical services not available in underserved areas (e.g., rural areas)
  - Remote telemonitoring/telemedicine provides specialist advice/treatment guidance to the patient's local providers of care without the need to travel
  - Use of mid-level providers (e.g., nurse practitioners, physician assistants or certified nurse specialists) can be more cost efficient
  - Retail health clinics can provide basic preventive care and primary care services

Care Delivery Enhancers (cont.)

- Each of the strategies previously described can result in faster and more appropriately-timed access to needed and higher quality care, at a potentially lower cost resulting in:
  - Improved quality due to a reduction in duplication of services
  - Improved access to appropriate care in remote locations
  - Improved access through expanded available hours for care
  - Improved access through a reduction in waiting times
  - Reduced health care costs as a result of reduced ER visits
  - Reduced health care cost due to a better match of patient acuity and provider level or site of service

Questions

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