Joint Commission on Health Care

Factors Affecting Health Care Costs (Part 2)

October 22, 2013

Stephen W. Bowman - Senior Staff Attorney/ Methodologist

House Joint Resolution 687 (2013)

- Patron: Delegate John M. O'Bannon, III
- Study Mandate:
  - Identify factors considered to be the primary contributors to increasing health care costs *(Reviewed May 2013)*
  - Report on promising policies, practices, and initiatives expected to help control health care costs while maintaining quality of care.
  - Review approaches undertaken in other states and countries to control health care costs, and
  - Examine the likely impact of federal Patient Protection and Affordable Care Act provisions on the cost of health care.

Will be reviewed by JCHC in 2014

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Agenda

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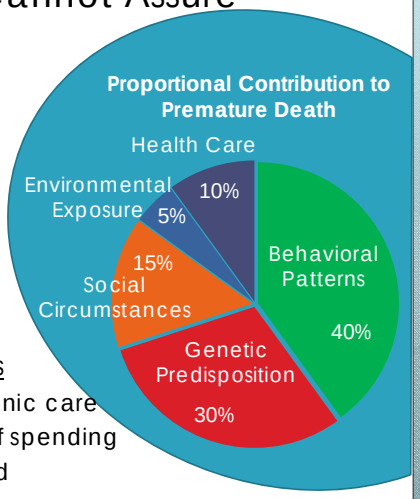
Background Highlights

- Health is influenced by much more than health care
- Health care costs and quality are impacted by many factors
- Virginia's health care infrastructure is not an organized system
- Reimbursement strategies of different payers may vary
- Provider price, quality and efficiency of care vary
- Other efforts to determine health care cost containment strategies are underway

Health Care Cost: Background 5

Excellent Health Care Cannot Assure an Individual's Health



Health Is Influenced by 5 Factors

- Genetic predisposition
- Social circumstances
- Environmental exposures
- Behavioral patterns, and
- Health care

U.S. Health Care Expenditure Facts

- 75% of expenditures related to chronic care
- 5% of individuals account for 50% of spending
- 3.5% is spent toward prevention and public health services

Sources: Steven A. Schroeder M.D., We Can Do Better-Improving the Health of American People, N Engl J Med 2007; 357:1221-8, GAO, Preventive Health Activities, December 2012 at http://www.gao.gov/assets/660/650617.pdf, and American Public Health Association, Issue Brief: The Prevention and Public Health Fund, July 2012 at http://www.apha.org/NR/rdonlyres/8FA13774-AA47-43F2-838B-1B0757D111C6/0/APHA_PrevFundBrief_June2012.pdf.

Health Care Cost: Background 6

Health Care Cost: Background 7

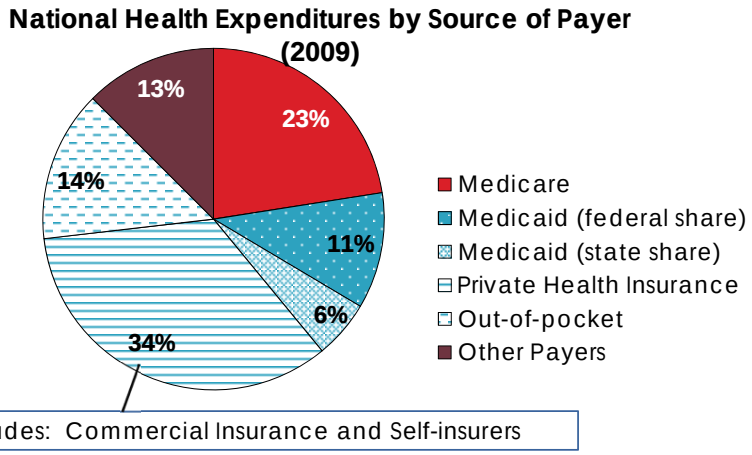
Virginia's Health Care Infrastructure is Not a Health Care System

- Patient care coordination between different market participants is a challenge
- Sometimes health care providers have little or no financial incentives for:
  - Improving population health
  - Providing medical "best practices"
  - Improving institutional safety
  - Decreasing medication errors
  - Providing transparent price and quality information
  - Changing practices towards higher-quality, lower-cost care
  - Ensuring patients stay healthy after leaving the provider's care
  - Coordinating with other providers
  - Reducing overall health care expenditures
  - Promoting a competitive health care market
- PPACA requires that tax-exempt hospitals, at least every three years, conduct a Community Health Needs Assessment.
  - A core standardized set of information could be collected to allow for a systemic understanding of Virginia population health and health care gaps

Source: The Hilltop Institute, Hospital Community Benefits after the ACA: The State Law Landscape, Issue Brief March 2013, http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAftertheACA-StateLawLandscapeIssueBrief6-March2013.pdf

Health Care Cost: Background 8

Health Care Payers Can Have Different Reimbursement Strategies



Includes: Commercial Insurance and Self-insurers

Source: Centers for Disease Control and Prevention, Health, United States, 2011, In Brief Interactive Version at http://www.cdc.gov/nchs/hus/previous.htm.

Health Care Cost: Background 9

Price Variation Occurs for Health Care Provider Services

Private Insurer Payment Rates to Hospitals as a Percentage of Medicare

(Source: Center for Studying Health System Change, 2010)

Richmond Hospital Payment Rates	Inpatient	Outpatient
25th Percentile	171%	231%
50th Percentile	200%	275%
75th Percentile	238%	347%
Highest Payment rate with Volume	291%	495%
Average rate	192%	267%

Source: Paul Ginsburg, Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power, No. 16, November 2010 at http://www.hschange.com/CONTENT/1162/

Health Care Cost: Background 10

Health Care Costs Are Partially Driven By Variations in Provider Quality and Efficiency

Selected Quality and Efficiency Measures

(Example of 4 Top-Performing Hospitals)

Hospital Examples	Overall Heart Attack Care	Overall Heart Failure Care	Overall Pneumonia Care	Overall Surgical Care	30-day Readmission Rate for Pneumonia
Fairview Southdale	99.86	97.95	95.38	98.08	19.6
North Mississippi	98.91	97.24	97.13	97.38	17.8
Park Nicollet	99.4	96.22	96.65	96.2	19.3
Providence St. Vincent	98.66	95.57	97.37	97.1	15.6
National Top 10%	99.89	99.29	98.37	95.58	16.5
National Average	97.5	92.34	93	95.08	18.34

Source: Jennifer N. Edwards et al., Achieving Efficiency:
Lessons from Four Top-Performing Hospitals, Synthesis Report, July 2011, The Commonwealth Fund, at
http://www.improvegroup.net/images/ig_library_downloads/1528_Edwards_achieving_efficiency_synthesis_four_top_hosps_v3.pdf

Health Care Cost: Background

2 Basic Approaches to Reduce Health Care System Spending

Pay less for care

Use fewer services

Health Care Cost Literature Review

- Cost-effective reforms may not reduce spending
  - Reforms may increase spending and value
- "Majority of prevention services both add value to the health system and increase total costs."
- Comparative effectiveness and disease management programs may add value and increase costs

Source: RAND Health, Controlling Health Care Spending in Massachusetts: An Analysis of Options, August 2009, at http://www.rand.org/pubs/technical_reports/TR733.html.

Health Care Cost: Background

State Health Care Cost Containment Commission

U.S. News & World Report usnews.com

By MIKE LEAVITT, BILL RITTER

Cracking the Code on Health Care Costs

State leaders have the ability to reduce cost and improve the quality of health care

- Use governors as conveners and consensus builders
- Drive payment reform
- Encourage market competition and consumer choice
- Clean house on byzantine laws and regulations
- Promote wellness and prevention

Commission spearheaded by University of Virginia's Miller Center

Source: http://www.usnews.com/opinion/articles/2013/09/20/state-governments-can-crack-the-code-on-health-care-costs-and-quality_print.html

Health Care Economics

- Health care costs can be defined differently
- A perfectly competitive market assumes:
  - Consumers have the same information as suppliers
  - All firms have a small market share
- The amount of competition in a health care market can vary significantly
- Price is an important factor, especially for individuals with higher health care deductibles or the uninsured
- The *Code of Virginia* affirmatively promotes competition
- Virginia has the power to shield certain activities from federal anti-trust enforcement

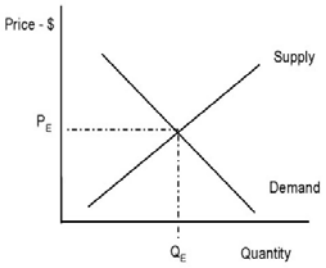
Types of Health Care Costs

Cost of Production	Provider cost to perform health care service; pharmaceutical company cost to develop and manufacture drug
Negotiated price of health care services or insurance	Insurers Provider or price negotiated with provider Drug price negotiated with Pharmacy Benefit Managers Employers insuring employees Per month premium paid to insurer (can change annually) Self-Insured Employers Total employee health care cost (rates directly negotiated with provider or through a third-party administrator)
Individual Expenditures	Individual Costs If uninsured, no negotiated rate *(provider discount possible)* Cost to purchase insurance Out-of-pocket payments
System Costs	Overall System Health Care Expenditures Combined expenditures of government, insurer, self-insured, and individual health care spending

Note: Consider the time-horizon when analyzing cost approaches

A Perfectly Competitive Market Meets 5 Criteria

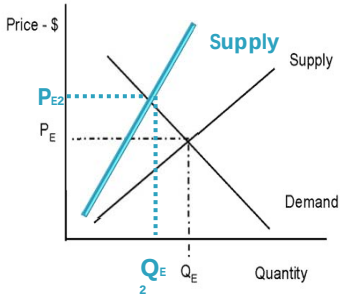
1) All firms sell an identical product;
2) All firms are price takers - they cannot control the market price of their product;
3) All firms have a relatively small market share;
4) Buyers have complete information about the product being sold and the prices charged by each firm; and
5) The industry is characterized by freedom of entry and exit.



Sources: Investopedia Image from Applying Economic Principles to Health Care R. Douglas Scott* , Steven L. Solomon*, and John E. McGowan† Author affiliations: *Centers for Disease Control and Prevention, Atlanta, Georgia, USA; †Emory University, School of Medicine, Atlanta, Georgia, USA.

The Health Care Market's Competitive Nature Can Vary

- Few markets are very close to meeting ***all*** criteria of a "perfectly competitive market."
  - E.g. agriculture, t-shirt retailers
- In some situations, certain health care services may not meet ***any*** of the "perfectly competitive" criteria.
  - e.g. 'Provider Z' is the only medical professional in a market. That provider can have some degree of control over the price of a service that is set and whether that price can be known by the consumer. The difficulty and capital required for a competitor to Provider Z to enter the market is high.



Example: Without a sufficient number of suppliers in a market, suppliers can increase the market price

Source: See previous slide (Blue P and Q E2 lines were added by JCHC staff and Hammoudeh, S, Econ 330, Lecture Notes Part 2, at http://faculty.ahnow.edu/shammoudeh/Econ_330.htm.

Health Care Economics 17

Consumer's Ability to Know Health Care Prices Prior to Receiving Care Allows for Better Decision Making

Medical costs: Transparent pricing would improve affordability

- "[T]here is one specialty of medicine that is open to complete price transparency and that is a field I work in every day — cosmetic surgery."
- "[P]rice is a critical factor for helping patients feel more confident about their final decisions"

Richmond Times Dispatch Guest Columnist: Isaac L. Wornom III, M.D.

Higher Deductibles Increase the Amount of Health Care Services Consumers Pay at the Provider-Reimbursed Rate

- In 2013, 78% of covered workers in Employer-Sponsored Health Plans have a general annual deductible (2013)
  - Up from 72% in 2012
  - Average Deductible: $1,135
  - 31% of covered workers have a deductible of at least $2,000

Sources: Richmond Times Dispatch, August 4, 2013 at http://www.timesdispatch.com/opinion/their-opinion/columnists-blogs/guest-columnists/medical-costs-transparent-pricing-would-improve-affordability/article_4eaa65d2-c6b9-5452-b194-54767ce8b6dd.html and Gary Claxton, et. Al, Health Benefits in 2013, Health Affairs 32: No. 9, 2013.

Health Care Economics 18

Promoting More Price and Quality Based Competition Is a Recurrent Theme

"Redefining Health Care: Creating Value-Based Competition on Results" *excerpts*

- Normal market functioning: "competition drives relentless improvements in quality and cost….Excellent competitors prosper and grow, while weaker rivals are restructured or go out of business."
- Health care market functioning: "large and inexplicable differences in cost and quality for the same type of care across providers and across geographic areas. Competition does not reward the best providers, nor do weaker providers go out of business. Technological innovation… does not drive value improvement"

-Michael E. Porter and Elizabeth O. Tiesberg
Harvard Business Review Press

Virginia Antitrust Law and State Power to Shield Certain Conduct From Federal Anti-trust Review

Virginia Antitrust Act (*Code of Virginia* § 59.1-9.1-18)

- Purpose: "[P]romote the free market system in the economy of this Commonwealth by prohibiting restraints of trade and monopolistic practices that act or tend to act to decrease competition."
- Non-profit hospitals are specifically allowed to reduce services or improve the quality of services if "such reduction or improvement will reduce, stabilize or limit cost increases." *Code of Virginia* § 59.1-9.4

State Action Antitrust Exemption *(see Slide 66)*

- In 1943, U.S. Supreme Court ruled that the federal antitrust laws do not apply to anticompetitive restraints imposed by a state "as an act of government."
- "Even if the conduct would otherwise violate the antitrust laws, no antitrust violation occurs."

Source: John J. Miles, Application of the State Action Antitrust Exemption to Actions of State Medical Boards, American Medical Association, 2012 at http://www.ama-assn.org/resources/doc/arc/state-action-antitrust-exemption-white-paper-2012.pdf

Types of Cost Containment Approaches

Governmental

- Organize the System
- Provide Oversight
- Ensure Transparency and Analysis
- Convene and Build Consensus

Private Market

Note: Some governmental approaches can be used in conjunction with private market approaches

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Considerations to Pursuing Cost Containment Approaches

- Each approach may not be appropriate for a state, many factors could impact whether an approach should be pursued, such as:
  - Previous health care reforms
  - Degree of competition within provider and insurer market
  - Current payer reimbursement strategies
  - State's health care infrastructure
  - State's population health
- Evidence and opinions on the success of many approaches are mixed. Some disagreement centers on:
  - What health care costs should be the focus;
  - Whether the payer that reimbursed for the approach will receive the cost savings or comparable benefit;
  - Whether the approach has sufficient investment and momentum to succeed;
  - Whether success occurred or did not occur due to other factors or approaches;
  - How to quantify health (e.g. lack of health care related absences, presenteeism, productivity); and
  - Time-horizon used.

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Governmental Health Care Approach:

Organize the System

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Governmental Health Care Approach:

Provide Oversight

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Governmental Health Care Approach:
Ensure Transparency and Analysis

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Governmental Health Care Approach:

Convene and Build Consensus

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Private Market Approach:

Reimbursement

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Private Market Approach:

Provider Network

Slide #

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Private Market Approach:

Plan Design

Slide #

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JCHC Health Care Cost Study Activities Planned for 2014

1. Examine the likely impact of Patient Protection and Affordable Care Act provisions on the cost of health care
   - House Joint Resolution 687 (2012)
2. Report the percentage of US health care expenditures by sector compared to other countries
   - Requested at May 2013 JCHC meeting
3. Analyze provider, hospitals and insurer concentration by region
   - Requested at May 2013 JCHC meeting

Appendix includes: *(slides 99-132)*
- International population health comparisons (per request)
- Multinational Comparisons of Health Systems Data, 2012

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Policy Options

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Policy Options

Option 1: Take no action.

Option 2: Include in the 2014 work plan for JCHC, a two-year study of chronic disease prevalence in Virginia by geographic region. The study will identify demographic information, types of medical conditions, care-coordination, and treatment patterns for individuals with high-cost co-morbid chronic diseases, as well as options for improving such individuals' medical care and health.

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Policy Options

Option 3: By letter of the JCHC Chair, request a presentation in 2014 by the State Health Care Cost Containment Commission regarding strategies to transform health care in Virginia.

Option 4: By letter of the JCHC Chair, request a presentation in 2014 by the Virginia Chamber of Commerce regarding recommendations of Blueprint Virginia's Healthcare Industry Council.

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Policy Options

Option 5: By letter of the JCHC Chair, request that the Virginia Department of Health (VDH):

- Identify statewide core regional population health measurements, including options for their collection and dissemination;
- Consider leveraging existing efforts such as the Virginia Atlas of Community Health and the Community Health Needs Assessments (as mandated for not-for-profit hospitals) and consult (at a minimum) with representatives of:
  - Council on Virginia's Future
  - Department of Medical Assistance Services
  - Medical Society of Virginia
  - Virginia Association of Free and Charitable Clinics
  - Virginia Chamber of Commerce
  - Virginia Community Healthcare Association
  - Virginia Hospital & Healthcare Association
  - Virginia Rural Health Association
- Report to JCHC by October 2015 regarding conclusions and recommendations to improve measurement and tracking of population health in Virginia.

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Policy Options

Option 6: By letter of the JCHC Chair, request that representatives of the Virginia Hospital & Healthcare Association, the Medical Society of Virginia, and the Virginia Health Care Association convene to identify 25 quality and safety measures that if targeted could most improve hospital-related care, including readmissions.

As part of the review, the representatives are asked to determine the availability of the identified measures and whether the measures are currently collected and publicly reported; and if so, the frequency of collection; however if not collected, potential avenues for collection and dissemination; and finally to report to JCHC by October 2014 regarding conclusions and recommendations.

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Policy Option

Option 7: Include in the 2014 JCHC work plan, staff reports on health care cost-containment categories or specific approaches as determined by members of the Joint Commission on Health Care.

(See slides 22-28 for a listing of specific approaches)

A. Governmental Approach
   1. Organize the System
   2. Provide Oversight
   3. Ensure Transparency and Analysis
   4. Convene and Build Consensus

B. Private Market Approaches
   1. Reimbursement
   2. Provider Network
   3. Plan Design

Note: If this option is approved, categories and/or specific approaches will need to be selected as well

Note: Depending on the number of topics chosen, staff reports may continue beyond 2014.

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Policy Options

Option 8: In 2014, JCHC create a workgroup whose mission will be to review promising government- and market-based cost-containment, value, and efficiency strategies that also consider and maintain health care quality.

The suggested workgroup membership would include:

- Four members of the Joint Commission on Health Care
- Four business representatives *(chosen by the Virginia Chamber of Commerce)*
- Secretary of Health and Human Resources
- A health care economist *(chosen by the Virginia Chamber of Commerce)*
- The Director of the Council on Virginia's Future (or designated representative)
- The State Health Commissioner (or designated representative)
- The Director of the Department of Medical Assistance Services (or designated representative)

The workgroup's meetings will be open to the public and allow for presentations and input from health-care sector representatives. The workgroup will report to JCHC on findings and recommendations on a periodic basis as well as upon request.

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Public Comment

- Written public comments on the proposed options may be submitted to JCHC by close of business on November 12, 2013.
- Comments may be submitted via:
  - E-mail: sreid@jchc.virginia.gov
  - Fax: 804-786-5538
  - Mail: Joint Commission on Health Care
    P.O. Box 1322
    Richmond, Virginia 23218
- Comments will be summarized and included in the Decision Matrix which will be considered during the November 18th JCHC meeting.

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Governmental Health Care Approach:

Organize the System

Government Approach: Organize the System 39

1. SINGLE-PAYER SYSTEM (EXCLUDES MEDICARE AND MILITARY CARE)

ISSUE

- States are looking at different ways to address health care quality and cost challenges
- Vermont is pursuing avenues toward a single-payer health insurance system

APPROACH

- Example: Vermont
  - Created "a health care oversight board to control the rate of growth in health care costs, such as health insurance premiums."
  - "Requires detailed planning for a universal health care system that is nearly a single payer system"
    - Federal and military employees would be exempt.

Source: National Conference of State Legislatures, State Action Newsletter, Vermont's Single Payer Becomes Law, June 3, 2011, at http://www.ncsl.org/documents/health/ACANews11.pdf

Government Approach: Organize the System 40

2. ALL-PAYER RATE REGULATION

ISSUE

- "The U.S. is the only industrialized nation that does not actively reinforce the purchasing side of the health care marketplace through some form of government intervention."
- "All-payer systems can countervail the market leverage enjoyed by dominant provider groups, because fees would be established for all services and payers directly."

APPROACH

- "Under an all-payer rate-setting system, a public body would have the legal authority to establish the prices paid by both government and private health plans to hospitals and other providers for medical services. "
- "An all-payer system requires a common unit of payment and in its purest form mandates the payment level for a given service at a given provider across all patients. "
- "Service prices and corresponding payments could, however, vary for different providers, reflecting variations in input costs and the relative illness severity of patients."

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf and JCHC staff.

Government Approach: Organize the System 41

3. MARYLAND-TYPE HEALTH CARE RATE-SETTING

ISSUE

- "When the system began, Maryland's adjusted costs for hospital admissions were about 26% higher than the national average. The state's hospitals between 1977 and 2009, however, had the lowest cumulative increase per admission of any state in the nation."
- "For fiscal year 2009, the average cost per admission at Maryland hospitals increased 2% compared with a 4.5 percent increase for the rest of the nation."

APPROACH

- "Maryland established an all-payer hospital rate setting program in 1971 that still operates today. The program's goals, which continue today, are to :
  - Constrain hospital costs.
  - Provide financial stability for hospitals.
  - Offer efficient and effective care.
  - Finance the growing amount of uncompensated care hospitals face."
- "Rates are set for each diagnosis—for example, all hospital care for a pancreas transplant—as opposed to each separate service provided, such as sutures, an ultrasound, anesthesia, etc. This is to encourage hospitals to focus on controlling the overall cost of each episode of care rather than the myriad services required for one procedure."

Source: Richard Cauchi, et al, Uncovering Hospital Charges: September 2013 State Legislatures Magazine, at http://www.ncsl.org/issues-research/health/uncovering-hospital-charges-sl-magazine.aspx.

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Governmental Health Care Approach:

Provide Oversight

Slide #

Government Approach: Oversight 43

1. MASSACHUSETTS: CREATE POLICY AND INFORMATICS AGENCIES

ISSUE

"The law I have signed makes the link between better health and lower costs, that we need a real health care system in place of the sick care system we have today. What we're really doing is moving towards a focus on health outcomes, and a system to reward that. We are ushering in the end of fee-for-service care in Massachusetts in favor of better care at lower cost."

Massachusetts -Gov. Deval Patrick

APPROACH

2 New Health Care Entities Created

Health Policy Commission:

"Administers the Health Care Payment Reform Fund; conducts annual cost trend hearings; develops best practices and standards for development of alternative payment methodologies (APMs); certifies provider organizations, ACOs, and patient-centered medical homes; establishes and reviews health care cost growth benchmarks; oversees performance improvement plans; conducts market impact reviews; includes the Office of Patient Protection"

Massachusetts Center for Health Information and Analysis (CHIA)

"Collects provider cost data and information from private and public health care payers; develops uniform reporting of a standard set of quality measures; conducts annual report on quality and provider and payer cost trends; participates in and supports the Commission's cost trend hearings; analyzes data to identify payers and providers whose increases in health status adjusted total medical expense is excessive; maintains consumer health information website"

Source: Health Care Payment Reform Conference Committee Report at http://www.mass.gov/governor/agenda/healthcare/cost-containment/summary-health-care-payment-reform-conference-committee-report.pdf and Governor Patrick, press release August 6, 2012 http://www.mass.gov/governor/pressoffice/pressreleases/2012/2012806-governor-patrick-signs-health-care-reform.html

Government Approach: Oversight 44

2. MASSACHUSETTS: COST GROWTH TARGET AND TRANSITION PAYMENTS

ISSUE

- "'Cracking the code' on health care costs is essential for the long-term economic competitiveness"

APPROACH

Massachusetts Chapter 224 (2012)

- Sets targets for health care costs growth
- Requires Medicaid and State Employee Plan to move to other payment methodologies
- Authorizes increased payments for providers that transition to new payment methodologies
- Requires health care providers to report on market share, cost trends, financial performance, and quality measures.
- Sets up entity to monitor trends in health care industry

Source: Massachusetts Health Care Cost Legislative Summary, http://www.mass.gov/governor/agenda/healthcare/cost-containment/health-care-cost-containment-legislative-summary.pdf

Government Approach: Oversight 45

3. EXPAND INSURER AND PROVIDER CONTRACTING REGULATION

ISSUE

- Significant variation of health care provider prices exists
- Little oversight exists regarding provider-health plan contracting

APPROACH

- "Several states, including Massachusetts and Rhode Island, are experimenting with new ways of exercising oversight of health plans and their contractual arrangements with providers."
- "These activities can range from applying voluntary targets and goals for insurers (in terms of the structure of payment they use with providers, how much they pay for primary care, and other activities) to more stringent requirements, such as a requirement that enables them to negotiate separately with one hospital within a network instead of taking an all-or-nothing contract for all system members."

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf and JCHC staff.

Government Approach: Oversight 46

4. ENCOURAGE PRO-COMPETITIVE INSURER-PROVIDER CONTRACTING RULES

ISSUE

- Tiered networks can rank providers based on cost and quality information
- Some dominant providers may impede consumers being able to choose high-value hospitals

APPROACH

"Encourage pro-competitive rules for insurer-provider contracting:

- Prohibit providers from requiring placement in the preferred tier as condition of contracting;
- Restrict "all-or-nothing contracting" for providers that have multiple distinct units; and
- Ban "most-favored nation contracting" between providers and insurers.

Source: Bipartisan Policy Center, A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment, April 2013, at http://bipartisanpolicy.org/sites/default/files/BPC%20Health%20Care%20Cost%20Containment%20Report%20Executive%20Summary.pdf

Government Approach: Oversight 47

5. PROHIBIT REIMBURSEMENT FOR CERTAIN MEDICAL ERRORS

ISSUE

- "About one in seven patients experiences a medical error, of which 44 percent are preventable, according to the Office of Inspector General in the U.S. Department of Health and Human Services."
- "In fact, medical errors are the eighth leading cause of death in the United States and cost patients, insurers and governments more than $19.5 billion a year."

APPROACH

- "State legislatures also have enacted laws restricting or prohibiting payment for "never events," which are errors that result in serious harm, including surgery performed on the wrong body part, pressure ulcers from failing to manage incontinence and dry skin, and hospital-acquired infections such as pneumonia."
- "Maine prohibits health facilities from charging a patient or his insurer for 28 specific never events, and requires facilities to inform patients of the policy."
- "Medicare, several state Medicaid programs, and many commercial insurers also have adopted nonpayment policies."

Source: Richard Cauchi, et al, Great Ideas for Cutting Costs: July/August 2012 State Legislatures Magazine, at http://www.ncsl.org/issues-research/health/great-ideas-for-cutting-costs.aspx.

Government Approach: Oversight 48

6. SET LIMITS ON EMERGENCY CARE PRICING

ISSUE

- "Acute emergency care is inherently monopolistic since patients in an emergency situation have very limited ability to decide where they seek care."
- "When patients receive care out-of-network, providers often charge patients much more than what the providers accept from Medicare or private insurers with an established contract."

APPROACH

- "To protect consumers and help health plans when they negotiate with dominant provider systems, some have proposed the use of a Maximum Charge Level or Maximum Payment Obligation as a percentage of Medicare payment levels."
- "Legislating a maximum payment level in the case of emergency room care is a pro-competitive strategy in that it removes the pure monopoly pricing power of hospitals and consolidated systems."

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf and JCHC staff.

Government Approach: Oversight

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7. COMBAT FRAUD AND ABUSE

ISSUE

- "Fraud and abuse, widespread in both the public and private health care sectors, account for 3 percent to 10 percent of Medicaid payments nationwide. "
- "Among 28 federal programs examined by the U.S. General Accountability Office in 2007, Medicaid had the highest number of improper payments."

APPROACH

- "President Obama and health insurance executives plan to announce a new joint effort on Thursday to crack down on health care fraud by sharing and comparing claims data"
  - "For example, the official said, the new venture could identify a doctor who bills Medicare and two private insurers for a total of more than 24 hours of work in a single day."

- New York Times July 25th, 2012

Note: "Health care fraud is intentional deception-—a misrepresentation or failure to disclose pertinent information. A false claim involves an intentional false representation that causes the government to pay more than is allowable. Abuse involves substandard, negligent or medically unnecessary practices that increase the cost of health care."

Source: National Conference of State Legislatures, Combating Health Care Fraud and Abuse - Health Cost Containment, at http://www.ncsl.org/issues-research/health/combating-health-care-fraud-and-abuse.aspx and Robert Pear, *Obama and Insurers Join to Cut Health Care Fraud* at http://www.nytimes.com/2012/07/26/us/politics/obama-and-insurers-join-to-cut-health-care-fraud.html.

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Governmental Health Care Approach:
Ensure Transparency and Analysis

Gov't Approach: Transparency and Analysis 51

1. HEALTH CARE PRICE TRANSPARENCY

ISSUE

- Health care cost information by procedure is not consistently available prior to a provider visit
- For individuals with consumer-directed health plans who pay 100% out of pocket until the deductible is met this information may not be available and they will choose health care without any price information

APPROACH

- Multiple approaches exist for health care reimbursement and pricing to the consumer to be more transparent
- Health care cost price estimations by quartile range could be created for selected procedures and office visits
  - Estimates would be available for provider by insurer and if uninsured
  - Hospital charity care policies could be included on the website

Note: The price information does not have to be the specific rate to better inform consumers which providers offer lower cost options or treatments.

Gov't Approach: Transparency and Analysis 52

2. NC: HOSPITAL CHARGE AND PRICING INFORMATION PUBLISHED

ISSUE

- Price and charge information is not available for many medical services that allow patients to be more informed about their decisions

APPROACH

2013 North Carolina Law promotes more price transparency

- Hospitals and ambulatory surgical centers will have to post pricing and payments for their most common admissions, surgeries and imaging procedures.
- They will have to list the prices and the reimbursements from Medicare, Medicaid, large private insurers and uninsured patients.
- Hospitals must post their charity care policies prominently in their buildings and on their websites.

Source: Joseph Neff and Ames Alexander , Under new NC law, patients' hospital bills will be simpler, July 28, 2013, at http://www.newsobserver.com/2013/07/28/3064787/under-new-law-patients-hospital.html

Gov't Approach: Transparency and Analysis 53

3. NEW HAMPSHIRE: PRICE COMPARISON TOOLS

ISSUE

- Health care cost information by procedure is not consistently available prior to a provider visit
- For individuals with consumer-directed health plans who pay 100% out of pocket until the deductible is met this information may not be available and they will choose health care without any price information

APPROACH

State collects and disseminates average consumer cost for health care by provider and insurer that allows for cost comparisons

Detailed estimates for MRI - Knee (outpatient)

Procedure: MRI - Knee (outpatient)
Insurance Plan: Anthem - NH, Preferred Provider Organization (PPO)
Within: 1000 miles of 03301
Deductible and Coinsurance Amount: $1,000.00

Consumer Cost Estimate | **Precision Cost Estimate**

Lead Provider Name	Estimate of What you Will Pay	Estimate of What Insurance Will Pay	Estimate of Combined Payments	Precision of the Cost Estimate	Typical Patient Complexity	Contact Info
CONCORD HOSPITAL	$921	$0	$921	Low	MEDIUM	CONCORD HOSPITAL 603.228.7145
DERRY IMAGING CENTER	$930	$0	$930	MEDIUM	VERY LOW	DERRY IMAGING CENTER 603.537.1363
DARTMOUTH HITCHCOCK SOUTH	$1006	$28	$1034	LOW	MEDIUM	DARTMOUTH HITCHCOCK SOUTH 800.238.0505
NEW HAMPSHIRE OPEN MRI	$1028	$115	$1143	LOW	VERY HIGH	603.298.6736
DARTMOUTH HITCHCOCK - LEBANON	$1035	$144	$1179	MEDIUM	MEDIUM	DARTMOUTH HITCHCOCK - LEBANON 603.650.5000

Source: www.nhhealthcost.org

Gov't Approach: Transparency and Analysis 54

4. DEVELOP ALL-PAYER CLAIMS DATABASE (APCDs)

ISSUE

- "Comprehensive and timely APCDs are necessary for the development of payment models using global budgets or shared savings arrangements relating to a defined population."
- Health care's financing and disparate delivery systems for care is not integrated and transparent.

APPROACH

- "APCDs can be powerful tools to integrate and improve the highly fragmented and disparate elements of our health care financing and delivery systems by facilitating payment reform and system transparency."
- "These data also can be used to profile practice and utilization patterns, identify fraud/abuse, and determine overuse of high-cost services."

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf .

Gov't Approach: Transparency and Analysis 55

5. APCD ANALYSIS: HEALTH CARE SECTOR

ISSUE

- "There is an absence of data on physician services. Policymakers do not know how competitive physician markets are, whether they have become more or less competitive over time, or what the impact of those trends may be for price, quality of care, and other outcomes of import."

APPROACH

Potential analyses and reports using claims include:

- "Identifying 'hot spots' experiencing rapid increases in health care prices broadly speaking or in specific service lines (such as orthopedics, imaging, or emergency room services);"
- "Identifying areas that provide a market opportunity for the entry of lower cost providers (hospital, ambulatory care, or other);"
- "Identifying areas where costs are being controlled and quality of care is improving; highlight and analyze the factors associated with these developments."

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf and JCHC staff.

Gov't Approach: Transparency and Analysis 56

6. APCD ANALYSIS: "UNACCEPTABLE" TREATMENT VARIATION

ISSUE

- "Although a non-trivial amount of geographic variation can be explained by specific demographic and, potentially, health status variables, a substantial amount of variation remains unexplained."
- Massachusetts study: "Variation among specialists who work in the same group practice is as great as variation among specialists across the entire state."

APPROACH

- Claims-based quality measures are sparse in some specialized clinical areas however they are "plentiful and robust in other areas" (CMS, 2011)
- Using APCD claims data review variation in care by region, hospital and provider and assess whether variation is acceptable or unacceptable.
- For unacceptable care variations collaborate with appropriate state medical group to address such care variations

Source: Joseph P. Newhouse, et al., Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Care; , *Interim Report of the Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Health Care: Preliminary Committee Observations*, Institute of Medicine 2013, at http://www.iom.edu/Reports/2013/Geographic-Variation-in-Health-Care-Spending-and-Promotion-of-High-Care-Value-Interim-Report.aspx.

Gov't Approach: Transparency and Analysis 57

7. APCD ANALYSIS: UNADVISED "CHOOSING WISELY" TREATMENTS

ISSUE

- Some health care treatments are not advised for patients but are still being performed
- National organizations representing medical specialists have identified five tests or procedures commonly used in their field, whose necessity should be questioned and discussed.

APPROACH

- Using Virginia APCD data identify health care providers utilizing treatments that were identified by the medical specialty organizations.
- For such identified instances work with state medical groups to learn more about the appropriateness of the treatment
- If treatment was not appropriate, address such findings with the provider

Note: APCD claims do not incorporate clinical information that may show that the treatment was appropriate.

Source: Choosing Wisely website at http://www.choosingwisely.org/about-us/

Gov't Approach: Transparency and Analysis 58

8. APCD ANALYSIS: HEALTH CARE POLICY SIMULATIONS

ISSUE

- Health care policy and payment changes can have unanticipated impacts and obstacles
- Health policy impacts may not be seen or understood for years after adoption. Better information prior to choosing a government policy or market change allows for more effective policies to be implemented.

APPROACH

- Going forward, different health care policy strategies can be assessed with Virginia and region specific historical treatment and payment patterns.
- APCD data can be used to conduct micro-simulation analyses of impacts of certain potential avenues to better inform decision-makers.

Gov't Approach: Transparency and Analysis 59

9. INDEPTH ANALYSIS: HEALTH CARE COST AND QUALITY

ISSUE

- Providers know their individual reimbursement rates and internal quality metrics that may not be known or knowable by public or regulators.
- This lack of transparency can allow for market distortions and prevent healthcare chosen to be based on value.

APPROACH

- A law could be passed to provide a government agency the ability to examine health care cost variation, quality and reimbursements, including the ability to subpoena witness that would provide testimony under oath.
- A report of agency findings would be used to further health care system discussions and policies.
- Office of the Massachusetts Attorney General undertook this type of review

Source: Office of Attorney General Martha Coakley, Examination of Health Care Cost Trends and Cost Drivers, March 16, 2010, at http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf

Gov't Approach: Transparency and Analysis 60

10. REVIEW OF % AND TYPE OF PROVIDER REIMBURSEMENT CONTRACTS

ISSUE

- Reimbursement structure can encourage improvements in health care quality and efficiency
- Currently information is lacking on the prevalence of different reimbursement strategies

APPROACH

- Catalyst for Payment Reform (CPR) encourages paying for health care in a different way. CPR has selected measures to identify the amount of change in the types of reimbursements in a market.
  - Percent of commercial plan members attributed to providers participating in payment reform contracts
  - Share of total dollars paid to Primary Care Physicians and Specialists
  - Non-Fee-for-Service Payments and Quality
  - Plans that have consumer transparency products
  - Insured that enroll in transparency product tools

Source: Catalyst for Payment Reform, The National Scorecard and Compendium on Payment Reform, at http://www.catalyzepaymentreform.org/how-we-catalyze/national-scorecard

Gov't Approach: Transparency and Analysis 61

11. ONGOING ANALYSIS OF PROVIDER PRICING

ISSUE

- Some providers have the "ability of consolidated health systems to force insurers' self-responsible patients to pay excessively high prices"
- In the interest of an informed public discussion about restraining health care costs, additional information would allow for monitoring and assessing "the impacts of provider consolidation over time."

APPROACH

- Report "on the level, growth, and variation in provider prices is one of the first examples of a systematic investigation and evaluation of the negative effects of consolidated health systems using their market power to engage in price discrimination and generally drive up the cost of health care."
- "This had powerful implications for the state's health care marketplace and illustrates how monitoring and periodic reporting on the impacts of provider market power can help call attention to this issue."
- Example: Massachusetts Attorney General's 2010 and 2011 Report on Provider Pricing

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf and JCHC staff.

Gov't Approach: Transparency and Analysis 62

12. ONGOING ANALYSIS OF COMPETITION

ISSUE

- National concerns have been raised about:
  - "The growing concentration in health insurance markets and the potential for market domination by large insurers."
  - "The impact of hospital and physician consolidation on prices, quality and ultimately health insurance premiums and coverage."

APPROACH

- Health care provider and insurer competition could be measured using the Herfindahl-Hirschman Index (HHI) as a measure of market structure.
  - "The HHI is the sum of squared market shares in the market (usually in a Metropolitan Statistical Area or "MSA")."
  - "The index increases as market shares are more concentrated."
  - "It reaches its maximum value of 10,000 for a monopoly (the square of the monopolist's market share of 100 percent), and reaches a minimum value when the market is equally divided."
  - "The Department of Justice (DOJ) and Federal Trade Commission (FTC) guidelines define a market as "highly-concentrated" if the HHI exceeds 2,500."

Source: Robert Murray and Suzanne DelBanco, Provider Market Power in the U.S. Health Care Industry: Assessing its Impact and Looking Ahead, Catalyst for Payment Reform, 2012 at http://www.catalyzepaymentreform.org/2013-03-03-06-22-58/2013-03-04-03-29-59/market-power

Gov't Approach: Transparency and Analysis 63

13. REVIEW OF UPCODING IN EMERGENCY ROOM VISITS

ISSUE

- Without clear reimbursement guidelines, incentives exist for using higher-priced codes.
- "Between 2001and 2008, hospitals across the country dramatically increased their Medicare billing for emergency care, adding more than $1 billion."
  - Center for Public Integrity

APPROACH

- In order to examine whether this practice is occurring, APCD data could be used to analyze the type and frequency of emergency room codes used and compare with other hospitals within Virginia and nationally.

Source: Center for Public Integrity, Hospitals grab at least $1 billion in extra fees for emergency room visits, September 20, 2012 at http://www.publicintegrity.org/2012/09/20/10811/hospitals-grab-least-1-billion-extra-fees-emergency-room-visits

Gov't Approach: Transparency and Analysis 64

14. MEASUREMENT OF TRIPLE AIM

ISSUE

- "No single sector alone has the capability to successfully pursue improving the health of a population, the Triple Aim explicitly requires health care organizations, public health departments, social service entities, schools systems, and employers to cooperate."

APPROACH

- "Key measurement principles that apply to the Triple Aim are described below.
  - The need for a defined population: The frame for the Triple Aim is a population, and the measures, especially for population health and per capita cost, require a population denominator.
  - The need for data over time in improvement science, tracking data over time helps to distinguish between common cause and special cause variation, to gain insight into the relationship between interventions and effects, and to better understand time lags between cause and effect.
  - The need to distinguish between outcome and process measures, and between population and project measures."
- "While data tracked and plotted over time help to measure improvement, benchmark or comparison data enable comparisons with other systems."

Source: Institute for Health Care Improvement: Innovation Series 2012: A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost at http://www.ihi.org/knowledge/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx

Governmental Health Care Approach:

Convene and Build Consensus

Government Approach: Consensus Builder 66

1. STATE ACTION ANTITRUST EXEMPTION

ISSUE

- If payers and providers work together towards avenues that align provider reimbursement strategies towards lower costs, higher value, or increased system efficiency, concerns may be raised that such action may violate federal anti-trust laws. If a violation occurs the entities involved in the discussions may be prosecuted.

APPROACH

- The General Assembly could pass a "State Action Antitrust Exemption" statute that allows payers and providers to be convened to discuss strategies to reform provider payment approaches.
  - The statute will protect all parties from Federal antitrust actions
- All discussion on specific provider payment amounts could be prohibited
- Possible reimbursement strategies discussed:
  - Episode based and bundle payment
  - Global budgets and shared-savings
  - Population-based payments
  - Accountable Care Organizations
  - Emphasis towards Primary Care
  - Care coordination payments

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf , Center for Improving Value in Health Care and Colorado Health Institute, New Approaches to Paying for Health Care, July 2012 at http://www.coloradohealthinstitute.org/key-issues/detail/new-models-of-health-care/new-approaches-to-paying-for-health-care, and JCHC staff.

Government Approach: Consensus Builder 67

2. ALIGNMENT OF PUBLIC/PRIVATE REIMBURSEMENT STRUCTURES

ISSUE

- "Disparate payment structures and mechanisms contribute to the extreme fragmentation and administrative complexity of the health financing system in the U.S. and also likely significantly skew resource use in inefficient ways."

APPROACH

- "Alignment of public and private payer payment strategies would have the benefit of providing more consistent incentives to hospitals and physicians and would likely reduce variations in prices and costs."
- "Medicaid programs and private payers could consider aligning their payment methods with those of Medicare – both the current inpatient payment systems based on diagnostic-related groups (DRGs) and ambulatory payment classifications (APCs)."
- A concerted market effort could be used to rebalance primary care payments versus specialist payments

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf .

Government Approach: Consensus Builder 68

3. ALIGNMENT OF PROVIDER QUALTIY MEASURES AND REPORTING REQUIREMENTS

ISSUE

- "Large businesses are finding that their influence in promoting quality and value among health care suppliers is limited without the influence of the very largest purchasers: state or county employee benefit agencies and Medicaid. "

APPROACH

- "Multiple purchasers joining together to establish standard quality measures, which are translated into standard data requirements for health plans or providers."
- "The intent is to reduce the burden on suppliers of varied reporting requirements from purchasers (thereby enhancing cooperation); reduce confusion to employers and consumers when purchasing health care; and allow providers to focus on improving quality measures that reflect evidence-based medicine."

Source: Sharon-Silow Carrol and Tanya Alteras, Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve, The Commonwealth Fund, August 2007, at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2007/Aug/Value%20Driven%20Health%20Care%20Purchasing%20%20Four%20States%20that%20Are%20Ahead%20of%20the%20Curve/1052_Silow%20Carroll_value%20driven_purchasing%20pdf.pdf

Government Approach: Consensus Builder 69

4. GREATER INTEGRATION OF HEALTH: PHYSICAL AND MENTAL

ISSUE

- Many high-cost chronic conditions have co-existing mental health conditions
- Individuals with co-existing physical and mental health chronic conditions have higher physical health expenditures
  - Study: Average Physical Health Cost *(6,500 Medicaid patients)*
    - No psychological illness: $2,177
    - With psychological illness: $3,430

APPROACH

- VDH or other State entity review APCD data and other sources to assess the extent of mental and physical health integration within Virginia
- For high-cost populations, assess whether mental health services are needed, appropriately accessed and identify any underlying challenges in access, provision and financing, if appropriate.

Source: Roger Kathol, MD, CPE, Opportunities and Issues Related to BH Services in Primary Care presentation and Thomas, et al. Pysch. Serv. 56:1394-1401, 2005.

Government Approach: Consensus Builder 70

5. HIGH-VALUE, LOW-COST PREVENTION MEASURES

ISSUE

- "There is every reason to invest in a well-defined package of preventive services that are recognized as effective in preventing disease and offer good economic value."

APPROACH

- Identify, measure prevalence and when appropriate encourage the adoption of high-value, low-cost prevention measures (immunizations, etc...)

3 Types of Prevention Interventions

1. "Primary prevention can be accomplished by modifying unhealthy behaviors (e.g., smoking, physical inactivity), which cause many diseases and account for 38% of all deaths in the United States, administering immunizations to prevent infectious diseases, and reducing exposure to harmful environmental factors."
2. "Secondary prevention can reduce the severity of diseases, such as cancer and heart disease, through screening programs that detect the diseases or their risk factors at early stages, before they become symptomatic or disabling."
3. "Tertiary prevention—the effort to avoid or defer the complications of diseases after they have developed—is the current focus of medical care."

Source: Steven H. Woolf, MD, MPH, et al. The Economic Argument for Disease Prevention: Distinguishing Between Value and Savings, Partnership for Prevention, February 2009, at http://www.prevent.org/data/files/initiatives/economicargumentfordiseaseprevention.pdf

Government Approach: Consensus Builder 71

6. PHYSICIAN COMMUNITY ENGAGEMENT IN MORE HEALTH CARE VALUE AND COST DISCUSSIONS

ISSUE

- Physician can be unaware of the costs of tests and procedures ordered.
  - Example: "Hospitalists' awareness of inpatient charges appears subject to the same opacity of pricing known to limit patient knowledge, and at present hospitalists' cognizance of charges and costs is unlikely to facilitate decreased care expenditures."

APPROACH

- "Physicians' decisions determine which patients are seen in the office, how frequently, and by which practitioners; which patients are hospitalized; which laboratory tests, diagnostic procedures, and surgical operations are administered; which medications are prescribed; and which patients will be visited at home for care."
- Engage physician community more in health care value dialogues and avenues for improvement. A recent survey of physicians found:
  - 51% of physicians strongly disagreed that the cost of a test or medication is only important if the patient has to pay for it
  - 85% strongly or moderately agreed that trying to contain costs is the responsibility of every physician; and
  - 66% disagreed that there is too much emphasis on costs of tests and procedures."

Source: Jeremy D Graham et al, Hospitalists' awareness of patient charges associated with inpatient care, Journal of Hospital Medicine 2010;5:295–297 at http://onlinelibrary.wiley.com/doi/10.1002/jhm.655/abstract and Ezekiel J. Emanuel, MD, PhD; Andrew Steinmetz, BA, Will Physicians Lead on Controlling Health Care Costs?, JAMA 2013; 310(4):374-375. doi: 10.1001/jama.2013.60073.

Government Approach: Consensus Builder 72

7. VIRGINIA CENTER FOR HEALTH INNOVATION

ISSUE

- Movement towards higher-value care needs entities promoting greater adoption and resources.
- Center's goal is to accelerate "the adoption of value-driven models of wellness and health care in the Commonwealth of Virginia."

APPROACH

VIRGINIA HEALTH INNOVATION NETWORK

- The VHIN is a unique online learning, collaboration, and innovation network delivered via a social media platform that enables members to connect with potential partners and colleagues both in and outside their industries.
  - Learn about existing health innovations and models currently in practice
  - Connect with colleagues and join communities of interest
  - Share and spread what works and generate new innovations

Source: Virginia Center for Health Innovation website at http://www.vahealthinnovation.org/initiatives/the-network/

Government Approach: Consensus Builder 73

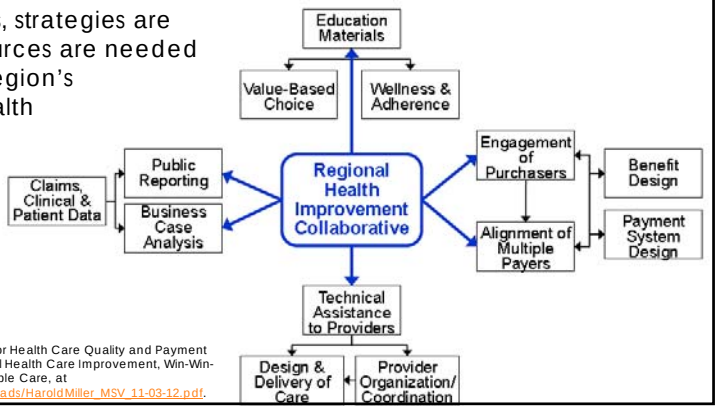
8. REGIONAL HEALTH CARE COLLABORATIVES

ISSUE

- Opportunities exist toward containing health care cost by improving health care coordination and population health
- Each region will have different infrastructure, health needs, and opportunities.

APPROACH

Multiple parties, strategies are information sources are needed to improve a region's population health



Source: Harold Miller, Center for Health Care Quality and Payment Reform & Network for Regional Health Care Improvement, Win-Win-Win Approaches to Accountable Care, at http://www.chqpr.org/downloads/HaroldMiller_MSV_11-03-12.pdf.

Government Approach: Consensus Builder 74

9. CONSUMER ENGAGEMENT: INFLUENCING BETTER AMBULATORY CARE

ISSUE

- "Medical errors are the eighth leading cause of death in the United States, higher than motor vehicle accidents, breast cancer or AIDS."
- "Each year, between 500,000 and 1.5 million Americans admitted to hospitals are harmed by preventable medical errors."

APPROACH

- " Consumer engagement in improving the quality of ambulatory care is in its early stages. "
- "A growing body of evidence from the hospital setting shows that in addition to transforming the culture of health care, putting patients in positions of genuine power and influence results in better-quality care.
- "Some hospital-based consumer engagement programs demonstrate outcomes that include reduced length of stay, fewer fatal safety errors, better identification of "near misses," and improved population health through achieving higher rates of preventive care."

Source: Aligning Forces for Quality, Lessons Learned: Engaging Consumers in Ambulatory Care, January 2012, at http://forces4quality.org/lessons-learned-engaging-consumers-improve-ambulatory-care-0 and NCSL, Health Care Cost Containment and Efficiencies, at http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf

Government Approach: Consensus Builder 75

10. CONSUMER ENGAGEMENT: CHOOSING WISELY CAMPAIGN

ISSUE

- Sometimes physicians and patients do not have the important conversations necessary to ensure the right care is delivered at the right time

APPROACH

- "*Choosing Wisely*® aims to promote conversations between physicians and patients by helping patients choose care that is:
  - Supported by evidence
  - Not duplicative of other tests or procedures already received
  - Free from harm
  - Truly necessary"
- "Leading specialty societies have created lists of "Things Physicians and Patients Should Question" — evidence-based recommendations that should be discussed to help make wise decisions about the most appropriate care based on a patients' individual situation."
- Encourage patients to be more engaged in treatment decisions for care they receive and choose not to receive

Source: Choosing Wisely website at http://www.choosingwisely.org/

Government Approach: Consensus Builder 76

11. CONSUMER ENGAGEMENT: ADVANCED CARE PLANNING

ISSUE

- "Most people have clear ideas of their end-of-life preferences, but few share these with family and physicians."
- "Advance care planning documents are designed to preserve a patient's final wishes."

APPROACH

- Washington state approach:
  - Washington End of Life Consensus Coalition was formed in 1997, a broad-based cross-section of individuals and organizations across the state interested in bettering end of life care.
  - Resources encourage and assist consumers to preserve their final wishes and provide peace of mind. Types of issues addressed are treatment choices that preserve quality of life, provide direction regarding life-sustaining treatment, as well as hospice and palliative care preferences.

Source: Washington State Medical Association, Know Your Choices, at https://www.wsma.org/for-physicians#societies

Government Approach: Consensus Builder

12. CONSUMER ENGAGEMENT: "ER is for Emergencies"

ISSUE

- Greater consumer education can encourage more appropriate use of medical care resources
  - When illness, accidents, and injuries happen individuals can have difficulty deciding where to go for care—doctor's office, urgent care clinic, or emergency room?

APPROACH

- Washington state approach:
  - A statewide campaign "to promote various patient-centered health initiatives and enhance the relationship between patient and physician."
  - ER is for Emergencies "promotes the Seven Best Practices program to redirect care to the most appropriate setting, and to reduce low acuity and preventable Medicaid emergency department visits. It attempts to address the root of the problem—chronic medical conditions, substance abuse issues, and lack of primary care access—focusing on high users."

Source: Washington State Medical Association, Know Your Choices, at https://www.wsma.org/for-physicians#societies

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Private Market Approach: Reimbursement

Private Market Approach: Reimbursement 79

1. GLOBAL PAYMENTS TO HEALTH CARE PROVIDERS

ISSUE

- "Research indicates global payments can lower costs without affecting quality or access where providers are organized and have the necessary data and systems in place."

APPROACH

- "In this system, fixed amounts are prepaid to a group or network of providers to cover most or all of a patient's care during a specific time."
- "Per-patient payments usually are made monthly instead of separately for each service."
- "In this system, providers in various settings are jointly accountable for the total cost of care through shared payments. Unlike managed care payments, providers, rather than insurers, make the treatment decisions."

Source: National Conference of State Legislatures, Health Costs: A New Look at Payment Reform Options, Vol . 18, No. 42 / October 2010 , at http://www.ncsl.org/issues-research/health/health-costs-payment-reforms.aspx

Private Market Approach: Reimbursement 80

2. EPISODE-OF-CARE OR BUNDLED PAYMENTS

ISSUE

- "Fee-for-service model lacks financial incentives for providers to manage the total cost of care for an episode of illness." This leads to inefficient, uncoordinated care

APPROACH

- "This model provides single payments for all care to treat a patient with a specific illness, condition or medical event (such as asthma or knee replacement). Although this payment system is in the early stages of development, research indicates cost savings for some conditions."
- "Medicare and several Medicaid programs pay hospitals a fixed rate per hospitalization, based on diagnosis. Researchers report "substantial and sustained reduction" in hospital costs and spending growth."
- "Federal health reform authorizes new Medicaid demonstration projects in eight states starting in 2012 to test episode-of-care payments. "

Source: National Conference of State Legislatures, Health Costs: A New Look at Payment Reform Options, Vol . 18, No. 42 / October 2010 , at http://www.ncsl.org/issues-research/health/health-costs-payment-reforms.aspx and Health Care Cost Efficiency Strategies, at http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf

Private Market Approach: Reimbursement 81

3. HIGH-INTENSITY PRIMARY CARE PAYMENT

ISSUE

- "To check soaring costs, some employers are switching from the inefficient fee-for-service model of paying for care, which encourages high volume and low quality, to payment models that reward high value."
- 5% of individuals account for 50% of health care costs

APPROACH

- "High-intensity primary care provides patient-centered, team-based care to those patients with the most significant health care needs (e.g., multiple chronic conditions)."
- "Patient's team of medical professionals (which may include a primary care physician, specialists, a behavioral health clinician, a nurse care manager, a health educator, and a community health worker) work together with the patient to support him or her in developing and following his or her individualized care plan."
- "This model of care often includes a significant level of patient-provider interaction (potentially daily) using in-person visits, telephone calls, and email."

Source: Academy Health, Payment Matters: The ROI for High-Intensity Primary Care Payment, February 2013, at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404563/subassets/rwjf404563_2

Private Market Approach: Reimbursement 82

4. PHARMACEUTICAL REIMBURSEMENT CONTRACTS

ISSUE

- "Reimbursement contracts, in which health insurers receive rebates from drug manufacturers instead of paying the transparent list price, are becoming increasingly common worldwide."

APPROACH

- Establishing "clear and consistent processes for negotiating contracts with relatively simple rebate structures and transparency to the public about the existence, purpose, and type of reimbursement contracts in place."

Source: Steven Morgan, et al., International Best Practices for Negotiating 'Reimbursement Contracts' with Price Rebates From Pharmaceutical Companies" , Health Affairs 32, No.4 (2013).

Private Market Approach: Reimbursement 83

5. NONPAYMENT OF MEDICAL ERRORS

ISSUE

- "According to the Institute of Medicine (IOM), more people die annually in hospitals as the result of adverse events than the number of deaths due to motor vehicle or workplace accidents, AIDS, or breast cancer."
- "In many cases evidence-based methods are available that can prevent these deaths and injuries."

APPROACH

- "Nonpayment for preventable adverse events or conditions represents one initial, relatively easy, visible, and noncontroversial step to purchasing quality care. These policies are an opportunity for purchasers to use their leverage to drive system improvement."
- "Alignment of state and federal policies should not stifle innovation; experimentation is needed prior to standardization. Federal policy should provide a floor but not a ceiling, so states can use their unique expertise and experiences to drive systems improvement."

Source: Jill Rosenthal and Carrie Hanlon, Nonpayment for Preventable Events and Conditions: Aligning State and Federal Policies to Drive Health System Improvement, National Academy for State Health Policy, December 2009, http://www.nashp.org/sites/default/files/PatientSafety.pdf.

Private Market Approach: Reimbursement 84

6. IMPROVE THE ACCURACY OF THE PHYSICIAN FEE SCHEDULE

ISSUE

- "The current Medicare fee schedule for physicians appears to have many distortions in payment levels; most notably, it rewards specialty procedures at the expense of primary care. "
- "To the extent that the current fee schedule overpays specialists and physicians performing procedures, it drives higher than necessary volumes and adds to the overall cost of health care for both public and private payers."

APPROACH

- "Most Medicaid departments and private payers benchmark their fee schedules using Medicare, changes to it have enormous potential to influence the entire payment system, with a consistent focus on incentivizing effective and efficient episodes of care for a broader patient population."
- "Employers and private payers should overcome anticipated resistance and help support current efforts by MedPAC and CMS to correct the known distortions in the Resource-Based Relative Value Scale system."

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf and JCHC staff.

Private Market Approach:

Provider Network

Slide #

Private Market Approach: Provider Network 86

1. ESTABLISH TIERED, NARROW, AND HIGH PERFORMANCE NETWORKS

ISSUE

- "Renewed employer willingness and resolve to demand narrower networks might bolster health plans in their ability to negotiate with dominant and higher-cost providers in a particular area."

APPROACH

- "Private payers somewhat successfully employed selective contracting – the use of limited networks of providers offering more favorable pricing – during the managed care domination of the 1980s and 1990s. Despite having suffered from the backlash against managed care largely due to the lack of quality information in the development of managed care networks, it is slowly gaining renewed attention."
- "Strategies could foster competition among providers if coupled with appropriate quality and performance information, employee benefit designs and decision-making support."

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf .

Private Market Approach: Provider Network[87]

2. ENCOURAGE CENTERS OF EXCELLENCE/DIRECT CONTRACTING

ISSUE

- Centers of Excellence (COEs) can increase "some small degree of competition into the market place while saving employers money. "
- "Most major health insurers use Centers of Excellence to direct patients to facilities that have demonstrable strengths – better clinical outcomes, fewer complications, and readmissions – for certain high-risk and/or high-cost procedures."

APPROACH

- "Direct contracting circumvents the traditional third-party relationship between providers and employers and places providers in direct contact with the customer."
- "For the short term, COEs also have the potential both to increase the transparency of health care – by forcing larger providers to post pricing and outcome data as they compete for contracts and volume – and shift volumes away from centers with substantial market power."

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf .

Private Market Approach: Provider Network[88]

3. ENCOURAGE ENTRY OF NEW, LOWER-COST COMPETITORS

ISSUE

- In some geographic areas, providers may have significant market power, which can lead to higher health care prices.

APPROACH

- "The entry of a well capitalized outside group in one instance (Boston) and a private insurer in the other (Pittsburgh) indicates that some see a market opportunity to undercut monopoly pricing strategies."
- "Employers and insurers should look for ways to encourage this type of strategy in other extremely consolidated markets."

Source: Robert Murray and Suzanne DelBanco, Provider Market Power in the U.S. Health Care Industry: Assessing its Impact and Looking Ahead, Catalyst for Payment Reform, 2012 at http://www.catalyzepaymentreform.org/2013-03-03-06-22-58/2013-03-04-03-29-59/market-power

Private Market Approach: Provider Network 89

4. OVERSEE ACO DEVELOPMENT

ISSUE

- "Employers need to be engaged and understand how the Accountable Care Organization (ACO) concept is being implemented in both the public and private sectors. "
- "Providers receive considerable antitrust exemptions under the provisions of the PPACA and could use health reform as cover for additional consolidation and integration with the aim of increasing their market power, leaving employers with little leverage."

APPROACH

- Employers should communicate "their expectations to their insurers/third party administrators for how to contract with Accountable Care Organizations. Monitoring efforts could include:
  - Insist that payment rates reflect cost decreases or increases significantly below historical trend.
  - Make the ability of the ACO to reap savings contingent on achievement of improved quality (including safety) relative to measures of importance to employers, and representative of the range of services for which the ACO is responsible.
  - Support a patient steerage strategy across contracted ACOs and within an ACO.
  - Provide enrollees with comparative information regarding provider performance, regardless of whether the employer chooses to use a benefit design with steerage."

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf .

Private Market Approach: Provider Network 90

5. ENCOURAGE PROVIDERS TO SUBMIT ADDITIONAL QUALITY DATA

ISSUE

- Some health care providers and facilities may not supply sufficient information for some quality rating organizations.
- Additional quality information can assist payer in being able to choose higher quality providers.

APPROACH

- Private health care payers could insert clauses in the payer-provider contracts that require or penalize hospitals that do not submit information to a quality rating service, such as the Leapfrog Group or Consumer Reports.

Private Market Approach:

Plan Design

1. NUDGE TOWARDS PROVIDER QUALITY

ISSUE

- Provider quality varies and company employees utilizing lower quality providers impacts the employee and the employer in health care costs and productivity.

APPROACH

Cracking Health Costs

by Tom Emmerick and Al Lewis

1. Employers should determine frequent lower cost procedures
2. Review where the procedures were done and associated quality ratings
3. Communicate and financially nudge employees towards higher quality hospitals
4. Communicate to hospitals about how the company is deciding on which hospitals to nudge employees to.

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf .

Private Market Approach: Provider Network[93]

2. ENCOURAGE DOMESTIC MEDICAL TOURISM

ISSUE

- Health care provider quality varies
- Companies seek to find less expensive high-quality care for their employees.

APPROACH

- "Example: Wal-Mart announced that their 1.1 million employees now have the option for heart and spine surgeries to be performed at six leading health systems with no copay or deductibles required, and travel costs also covered."
- "The companies believe sending patients to facilities with national reputations for both quality and value, where physicians and surgeons work under financial incentives rewarding improved patient outcomes, will result in improved care for patients and lower costs for employers."

Source: McKesson, ReveNews, Wal-Mart Joins Domestic Medical Tourism Movement , December 2012, at http://www.laboratory.mckessonrevenews.com/pdf/Q4_2012/McKesson_Laboratory_Editors_Picks_Q4_2012.pdf.

Private Market Approach: Plan Design 94

3. ESTABLISH REFERENCE AND VALUE PRICING

ISSUE

- Unwarranted provider reimbursement rates exist for some high-cost, high-volume procedures, in which quality is not thought to vary.
- Current payer-provider negotiated rates may not provide adequate incentives to promote consumers receiving health care value.

APPROACH

- "Reference pricing establishes a standard price for a drug, procedure, service, or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount."
- "Straightforward reference pricing can easily be built onto a fee-for-service payment structure."
- "Value pricing is reference pricing that takes quality into consideration and can be applied in many more circumstances, including for procedures and services where quality is thought to vary."

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf .

Private Market Approach: Plan Design 95

4. ENCOURAGE CONSUMER-DIRECTED HEALTH PLANS (CDHP)

ISSUE

- "In health insurance, there is an inherent tension between the benefit of reducing a person's exposure to financial risk and the drawback of reducing a patient's sensitivity to differences in price and quality among providers, which stems from the presence of 'first-dollar' insurance coverage"

APPROACH

- "CDHPs can be marginally effective to help younger and healthier patients make wiser and more parsimonious decisions about care options, such as avoiding unnecessary use of hospital emergency rooms. "
- "Care must be taken to structure CDHPs to avoid discouraging patients from seeking necessary preventive and primary care and shifting cost to chronically ill patients who routinely blow through their deductible amount because their care is inherently expensive."
- Patients should have pricing information prior to receiving care in order to make informed health care decisions with a CDHP.

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf .

Private Market Approach: Plan Design 96

5. ENCOURAGE VALUE-BASED INSURANCE DESIGN (VBID)

ISSUE

- "Employer-sponsored insurance has long attempted to direct patients to "preferred" providers based on some set of criteria.
- Health plans are "attempting to provide incentives for patients to seek hospitals and physicians who provide the highest value care."

APPROACH

- "Value-Based Insurance Design (VBID) – also referred to as tiered and high-performance provider networks engage consumers in making informed decisions about their care while still retaining choice of provider."
- "In a tiered network, health plans attempt to sort providers into tiers based on their relative performance on cost and quality metrics."
- "Providers achieving higher scores on efficiency and quality are placed in the preferred tier and patients are given incentives (through lower cost-sharing provisions) to choose these providers."

Source: Catalyst for Payment Reform. Provider Market Power in the U.S. Health Care Industry, Assessing its impact and Looking Ahead at http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf .

Private Market Approach: Plan Design 97

6. HELP PATIENTS DECIDE

ISSUE

- Unwarranted variations in medical care occur.
- Researchers at Dartmouth University estimate if unwarranted variation were reduced among the Medicare population, "costs could decrease by as much as 30 percent"

APPROACH

- "Although the aids do not yet identify the costs of the various treatment options, research indicates that patients who use decision aids tend to choose less costly, less invasive options than those who don't."
- "For example, patients with herniated disks who watched a video about their treatment options chose surgery 22 percent less often than patients who didn't watch it. Both groups had similar symptoms and results at three months and at one year."
- "Washington lawmakers in 2007 increased legal protections for physicians whose patients receive decision aids during informed consent. A large employer plan in Colorado gives patients a $50 gift card for using a patient decision aid."
- "These educational aids also helped patients make decisions more consistent with their values, according to a 2009 Judgment and Decision Making study from Wichita State University's Department of Psychology."

Source: Richard Cauchi, et al, Great Ideas for Cutting Costs: July/August 2012 State Legislatures Magazine, at http://www.ncsl.org/issues-research/health/great-ideas-for-cutting-costs.aspx.

Private Market Approach: Plan Design 98

7. EXPLORE EMPLOYER-SPONSORED COVERAGE: PRIVATE EXCHANGE

ISSUE

- As health care costs continue to increase, employers seek to identify ways to limit financial exposure for health care provided to their employees.

APPROACH

- "Private exchanges are marketplaces of health insurance and other related products. Employers purchase health insurance through the private exchange, and then their employees can choose a health plan from those supplied by participating payors. One big attraction of private exchanges is that they [can] facilitate the migration to a defined contribution model while allowing employers to retain some involvement in their employees' healthcare. "
- Walgreen, Sears Holding Corp, Holding Corp. and Darden Restaurants are in a private exchange run by Aon Plc. that includes 18 companies and 600,000 people.

Source: Drew Armstrong, Walgreen Joins in Exodus of Workers to Private Exchanges, Bloomberg, September 18, 2013, at http://www.bloomberg.com/news/2013-09-18/walgreen-joins-in-exodus-of-workers-to-private-exchanges.html and Akshay Kapur, et.al, The Emergence of Private Health Insurance Exchanges Fueling the "Consumerization" of Employer-Sponsored Health Insurance, Booz Allen, 2012 at http://www.booz.com/media/file/BoozCo-Emergence-Private-Health-Insurance-Exchanges.pdf.

99

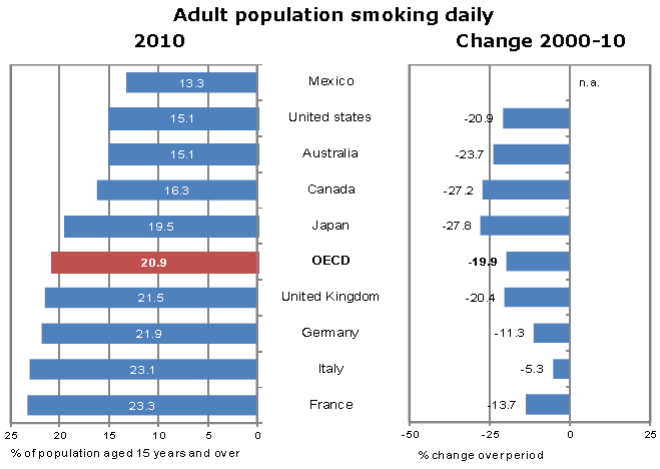
Appendix

JCHC Member Requested Information

The Commonwealth Fund: Multinational Comparisons of Health Systems Data, 2012

100

Smoking rates have decreased in the US and in most other OECD countries

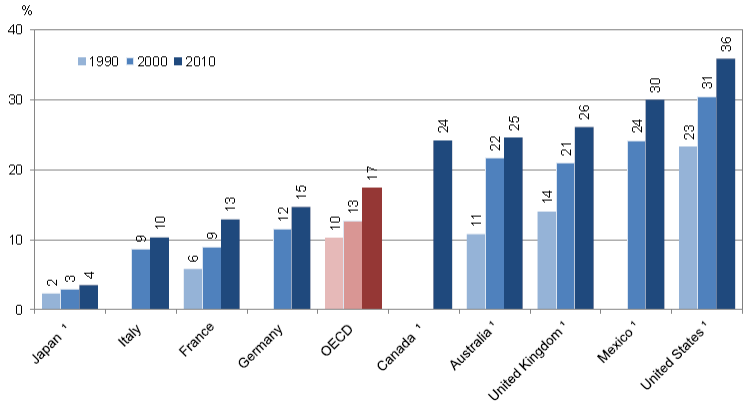


Organisation for Economic Co-operation and Development(OECD)

Source: OECD Health Data 2012, US Health Care System from an International Perspective, June 28, 2012.

101

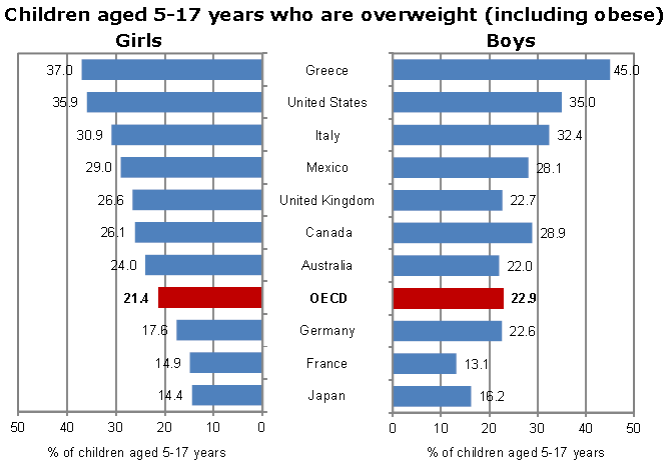
Obesity rates have increased substantially over the past 20 years and are highest in the US



Source: OECD Health Data 2012, US Health Care System from an International Perspective, June 28, 2012.

102

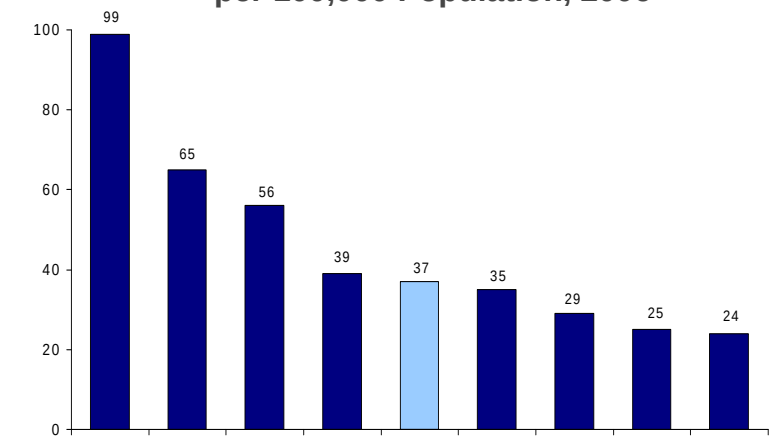
Over one-third of children in the US are overweight or obese



Source: OECD Health Data 2012, US Health Care System from an International Perspective, June 28, 2012.

103

Potential Years of Life Lost Due to Diabetes per 100,000 Population, 2006



* 2005
**2004

Source: Gerard F. Anderson and Patricia Markovich, Multinational Comparisons of Health Systems Data, 2008, The Commonwealth Fund using OECD Health Data 2008, "June 2008."

Multinational Comparisons of Health Systems Data, 2012

David Squires
The Commonwealth Fund

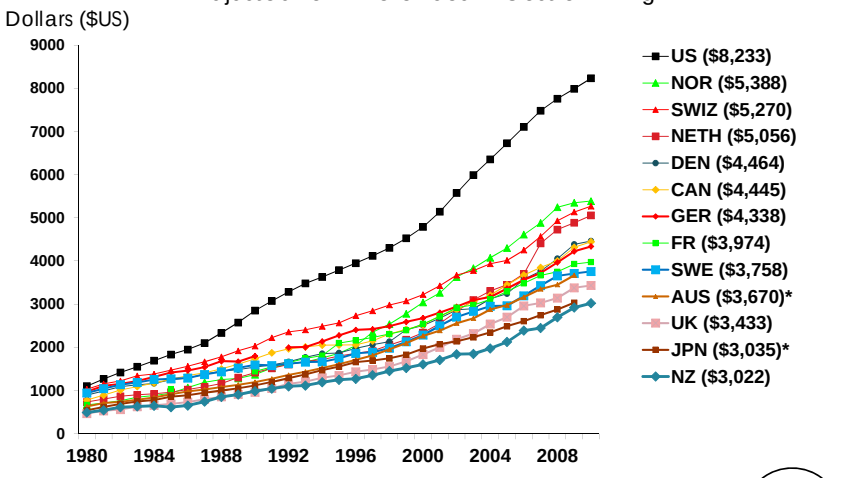
November 2012

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at

105

Average Health Care Spending per Capita, 1980–2010

Adjusted for Differences in Cost of Living



* 2009

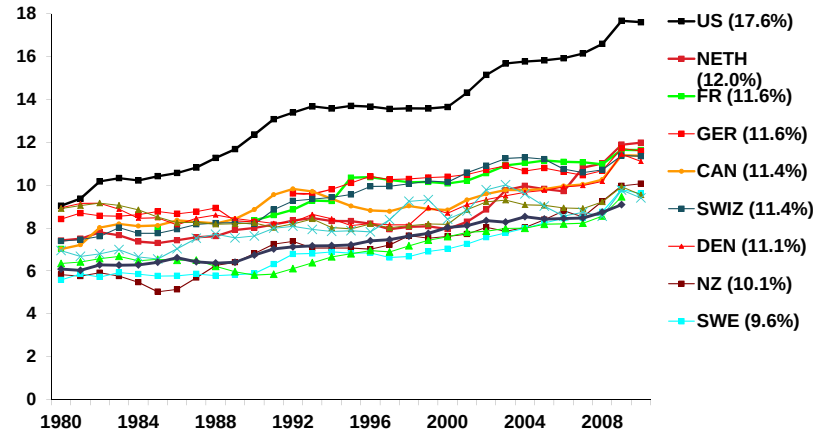
Source: OECD Health Data 2012.

THE COMMONWEALTH FUND

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

106

Health Care Spending as a Percentage of GDP, 1980–2010

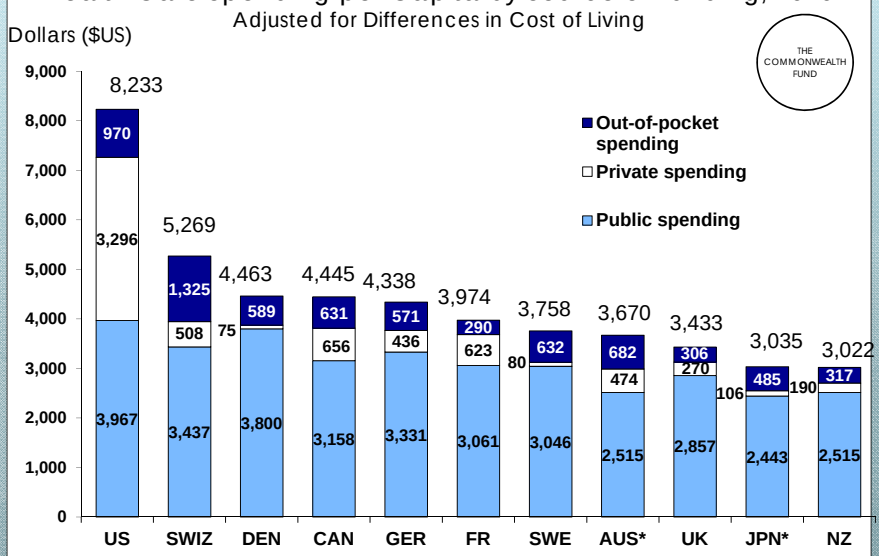


* 2009 GDP refers to gross domestic product. Source: OECD Health Data 2012.

THE COMMONWEALTH FUND

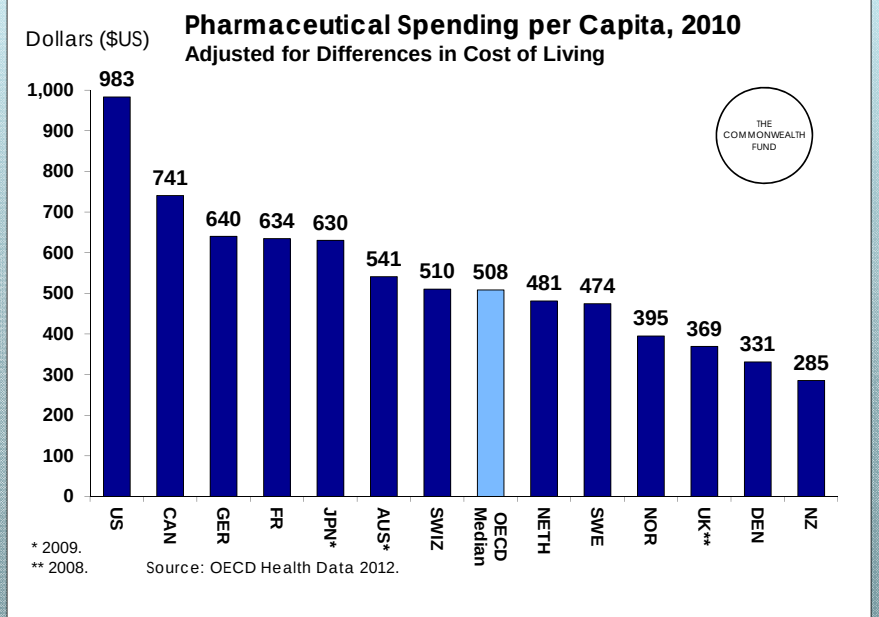
Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

107



Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

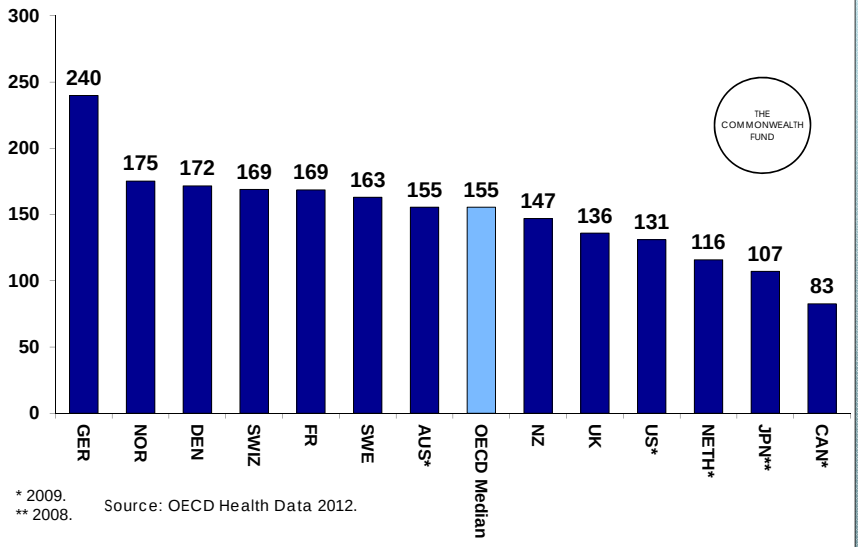
108



Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

109

Hospital Discharges per 1,000 Population, 2010



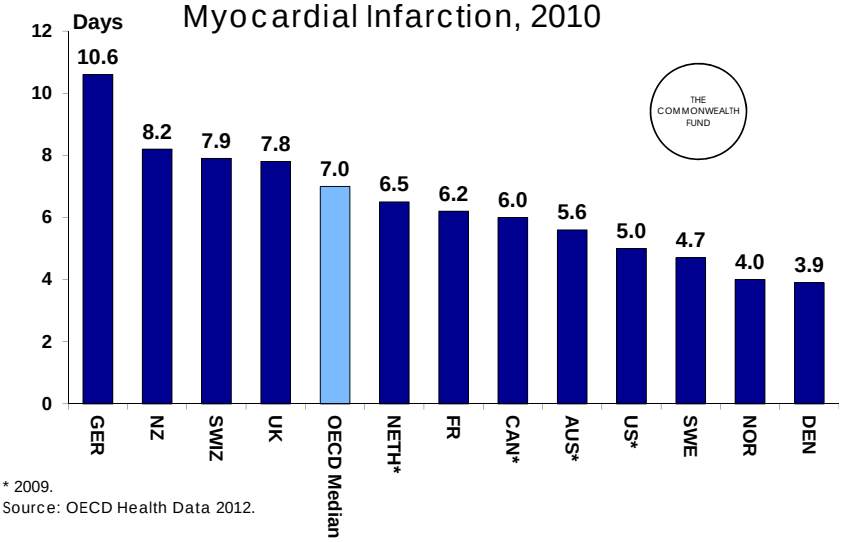
* 2009.
** 2008.

Source: OECD Health Data 2012.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

110

Average Length of Hospital Stay for Acute Myocardial Infarction, 2010



* 2009.

Source: OECD Health Data 2012.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

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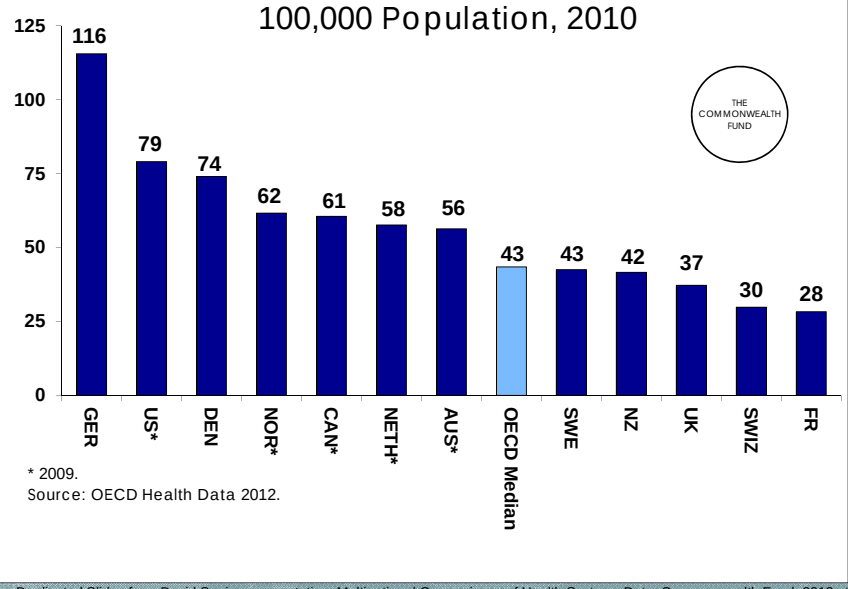
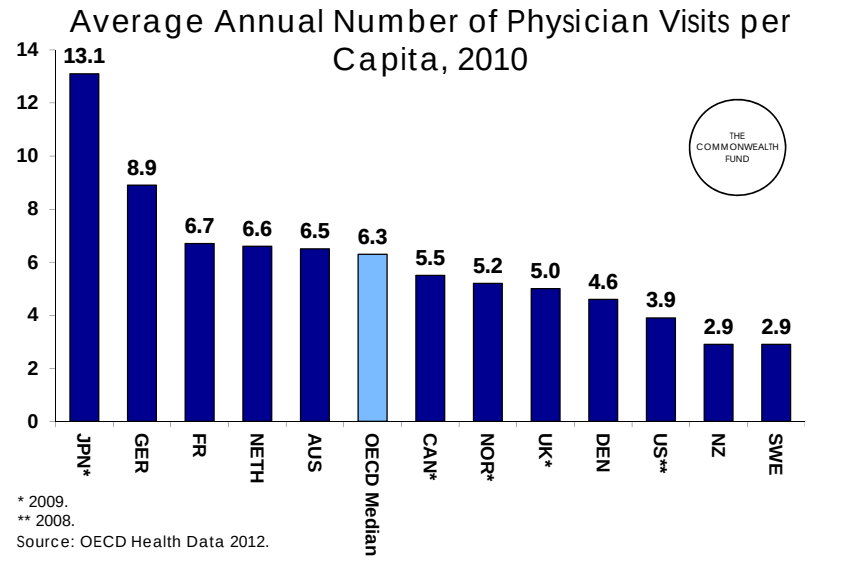


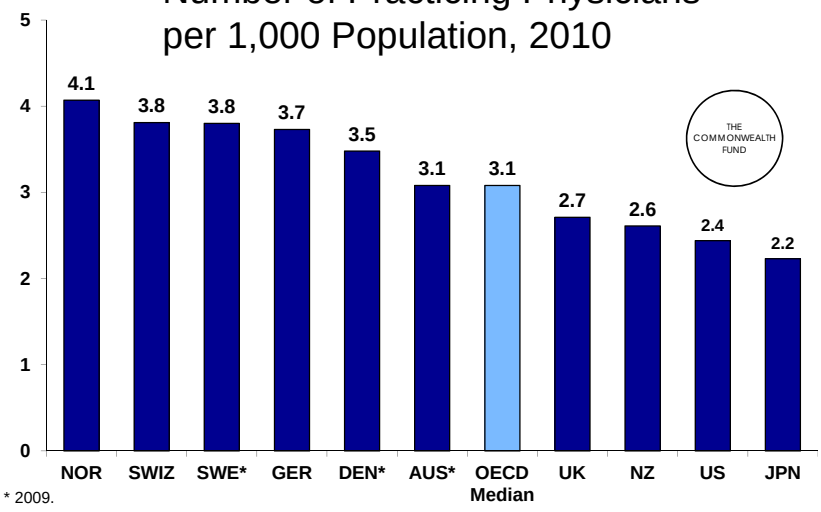
Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

112



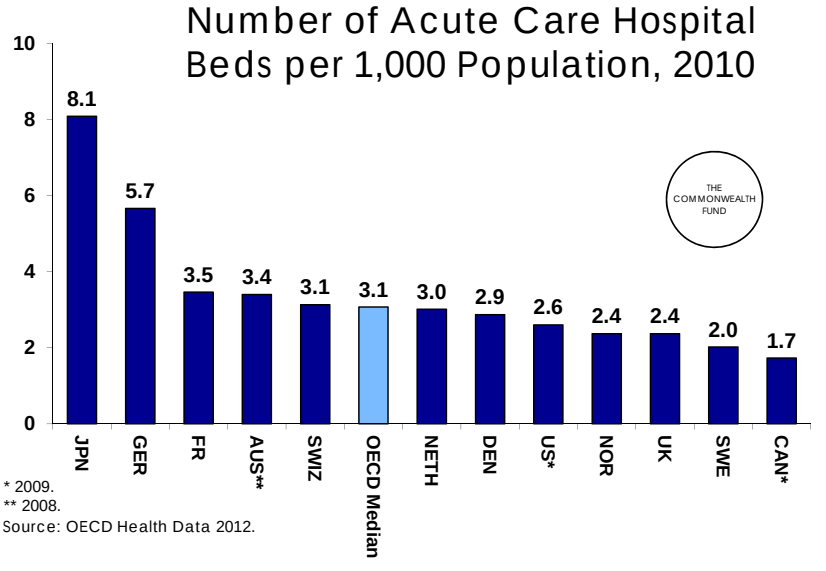
Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

113



Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

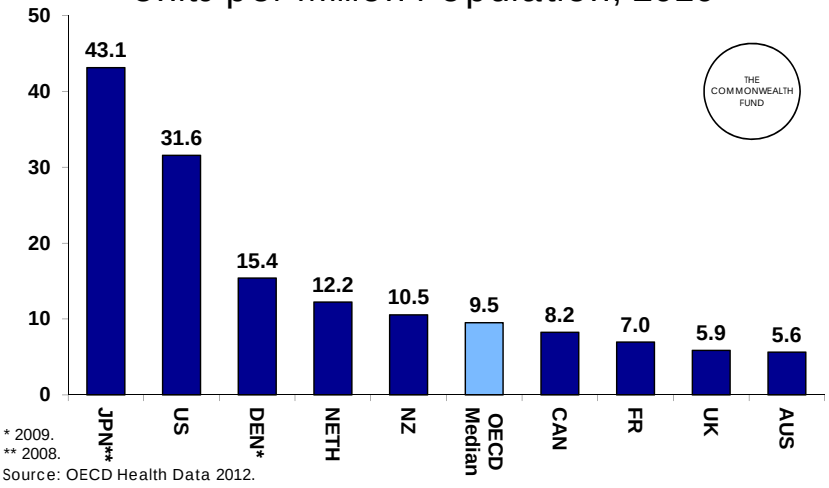
114



Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

115

Magnetic Resonance Imaging (MRI) Units per Million Population, 2010

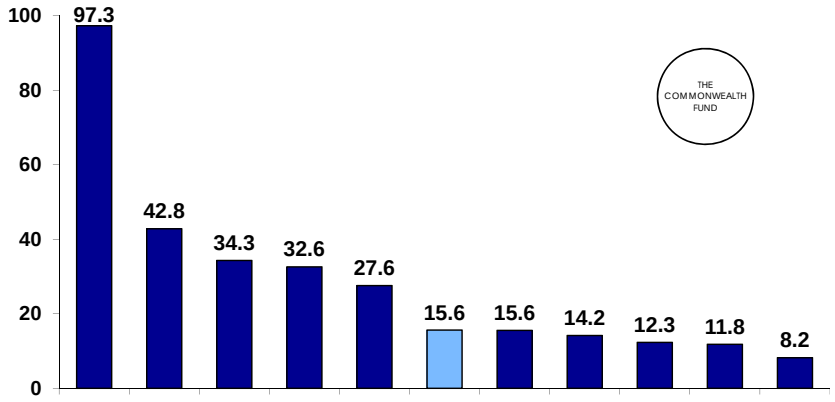


* 2009.
** 2008.
Source: OECD Health Data 2012.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

116

Computed Tomography (CT) Scanners per Million Population, 2010

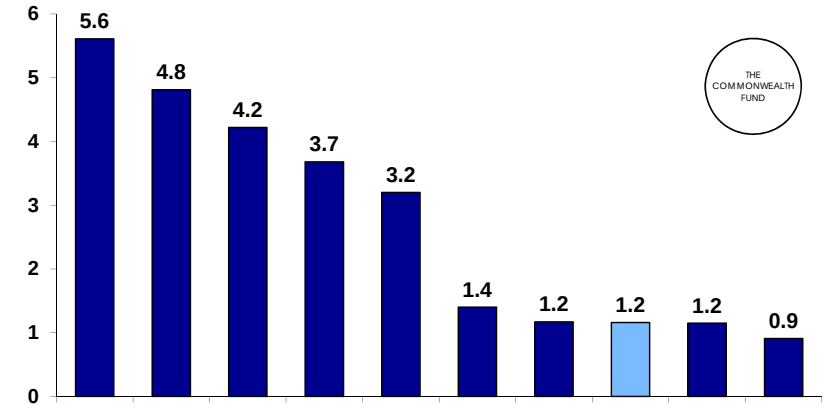


** 2008.
*** 2007.
Source: OECD Health Data 2012.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

117

Positron Emission Tomography (PET) Scanners per Million Population, 2010

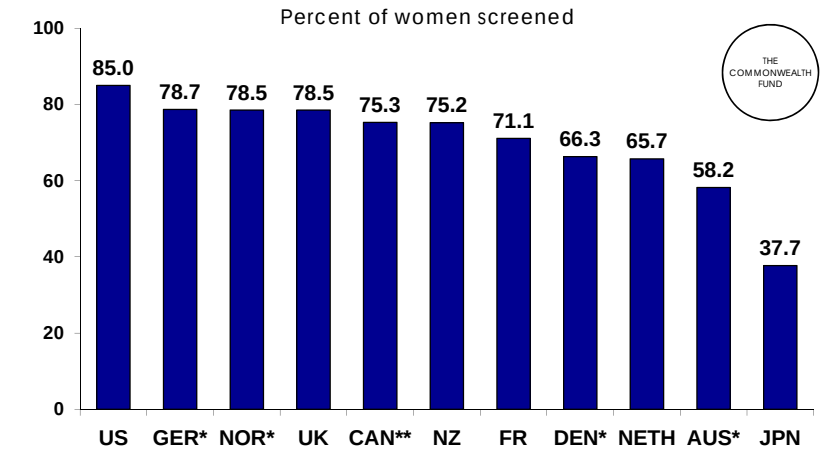


* 2009.
** 2008.
Source: OECD Health Data 2012.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

118

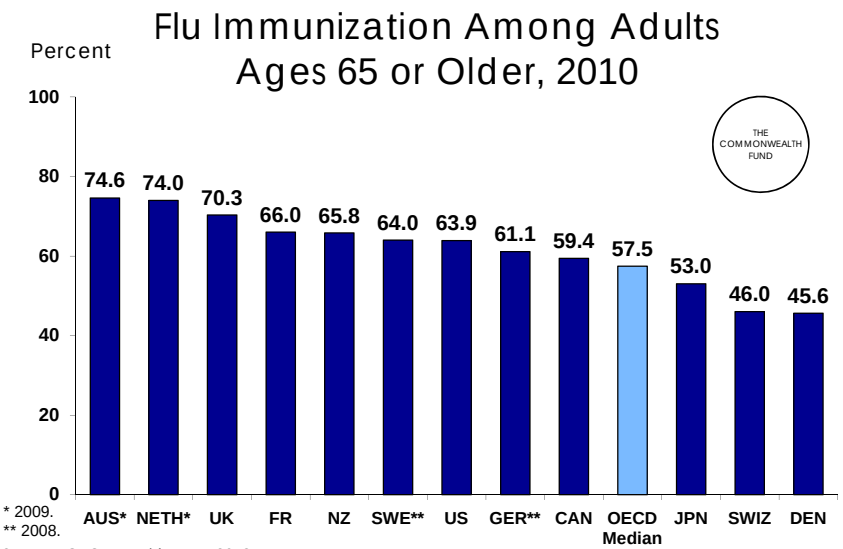
Cervical Cancer Screening Rates, 2010



Note: Norway, UK, NZ, Denmark, and Australia based on program data; all other countries based on survey data.
Source: OECD Health Data 2012.
* 2009.
** 2008.

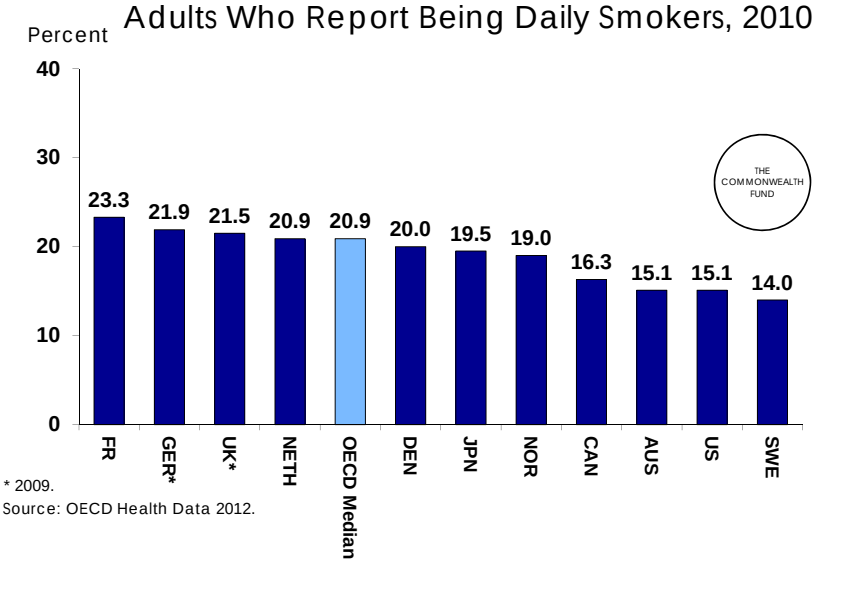
Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

119



Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

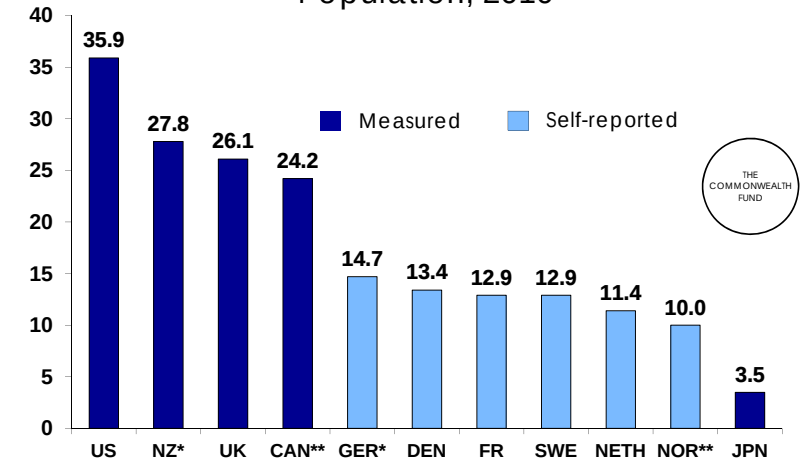
120



Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

121

Obesity (BMI>30) Prevalence Among Adult Population, 2010



Note: Body-mass index (BMI) estimates based on national health interview surveys (self-reported data) are usually significantly lower than estimates based on actual measurements.

* 2009.

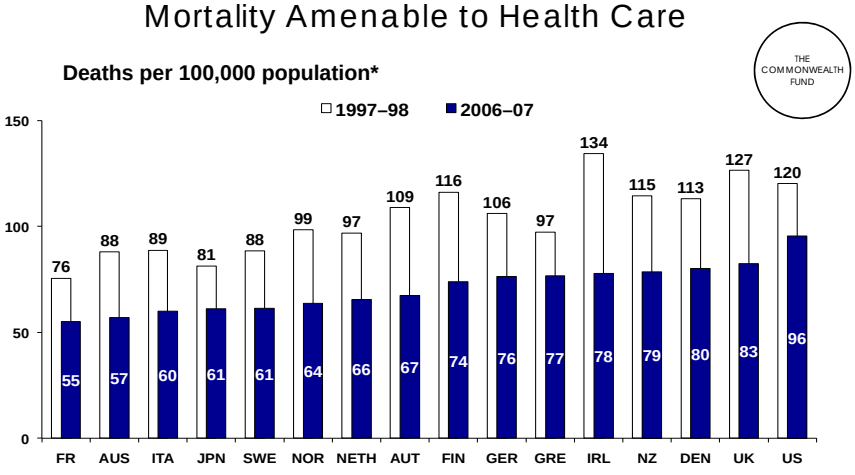
** 2008.

Source: OECD Health Data 2012.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

122

Mortality Amenable to Health Care

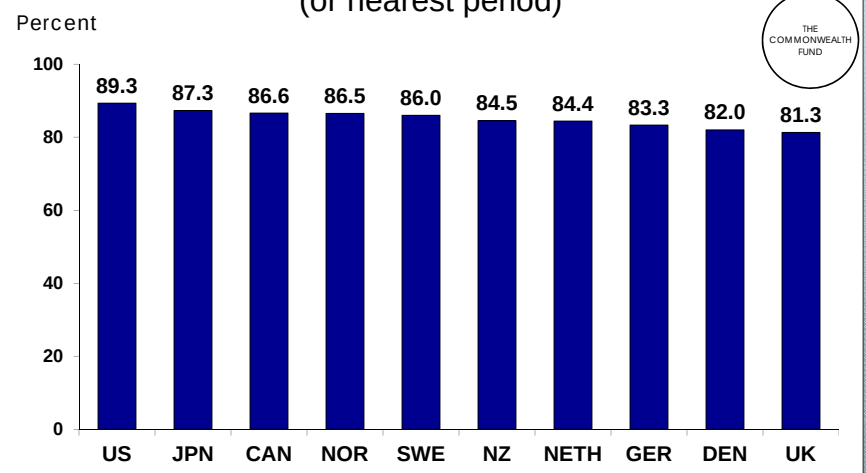


* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections. Analysis of World Health Organization mortality files and CDC mortality data for U.S.

Source: Adapted from E. Nolte and M. McKee, "Variations in Amenable Mortality—Trends in 16 High-Income Nations," *Health Policy,* published online Sept. 12, 2011.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

Breast Cancer Five-Year Relative Survival Rate, 2004–2009 (or nearest period)

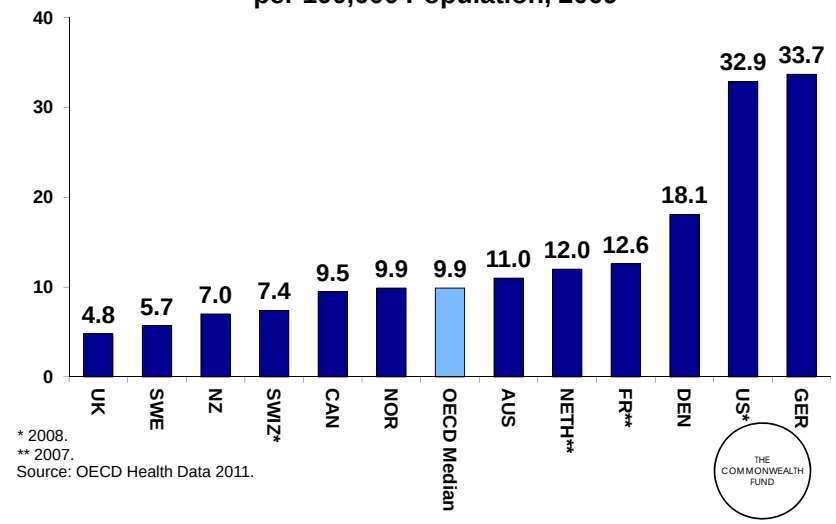


Source: OECD Health Data 2011.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

124

Diabetes Lower Extremity Amputation Rates per 100,000 Population, 2009

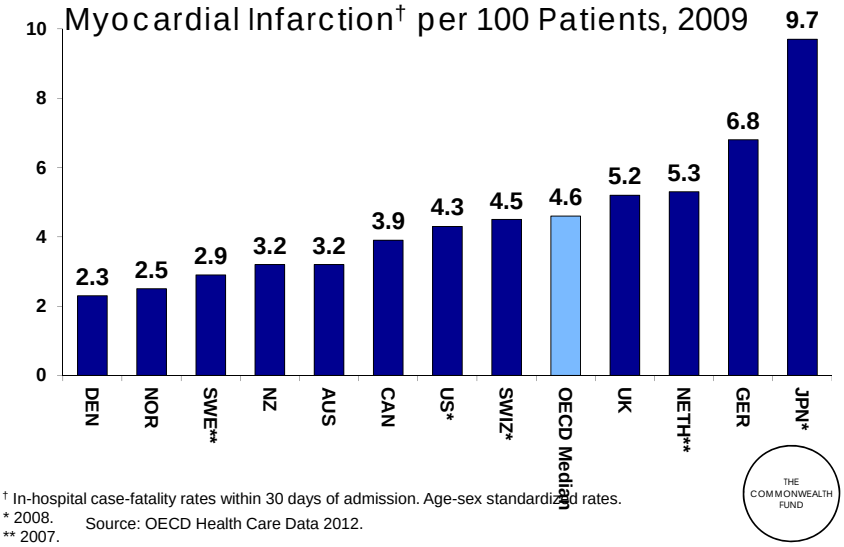


* 2008.
** 2007.
Source: OECD Health Data 2011.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

125

In-Hospital Mortality After Admission for Acute Myocardial Infarction† per 100 Patients, 2009



† In-hospital case-fatality rates within 30 days of admission. Age-sex standardized rates.
* 2008.
** 2007.
Source: OECD Health Care Data 2012.

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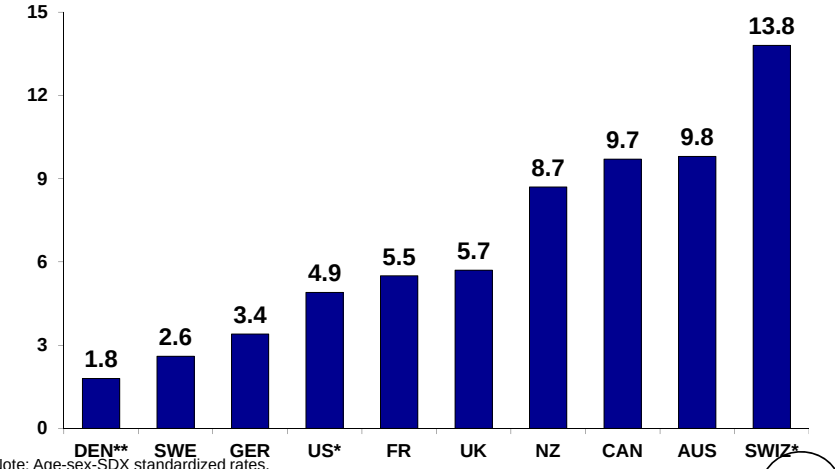
Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

126

Foreign Object Left in Body During Procedure per 100,000 Hospital Discharges, 2009



Note: Age-sex-SDX standardized rates.
* 2008.
** 2010.
Source: OECD Health Care Data 2012.

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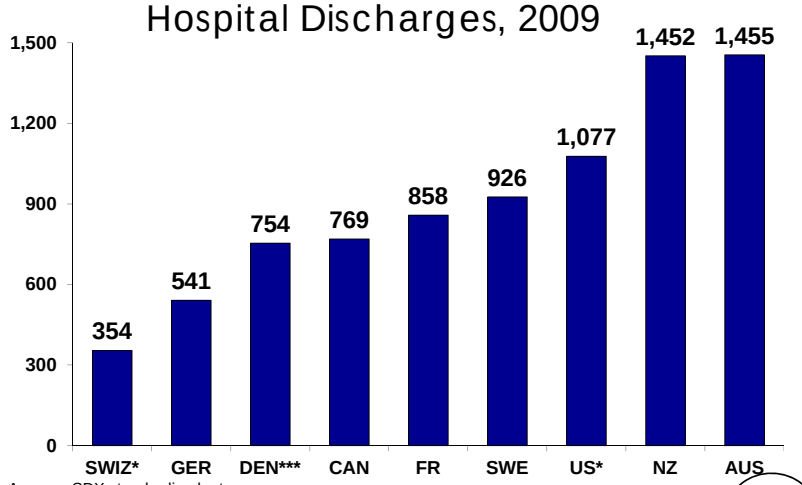
Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

127

Postoperative Sepsis per 100,000 Hospital Discharges, 2009



Note: Age-sex-SDX standardized rates.
* 2008.
** 2007.
*** 2010.
Source: OECD Health Care Data 2012.

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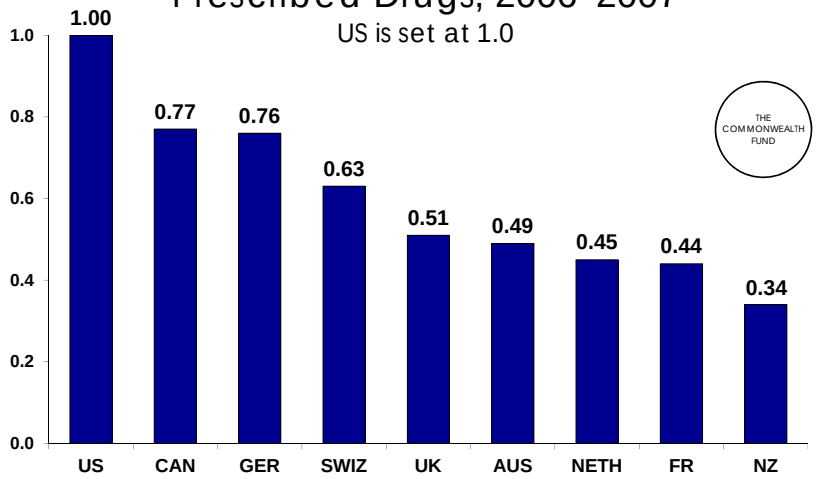
Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

128

Drug Prices for 30 Most Commonly Prescribed Drugs, 2006–2007

US is set at 1.0



Source: IMS Health; analysis by Gerard Anderson, Johns Hopkins University.

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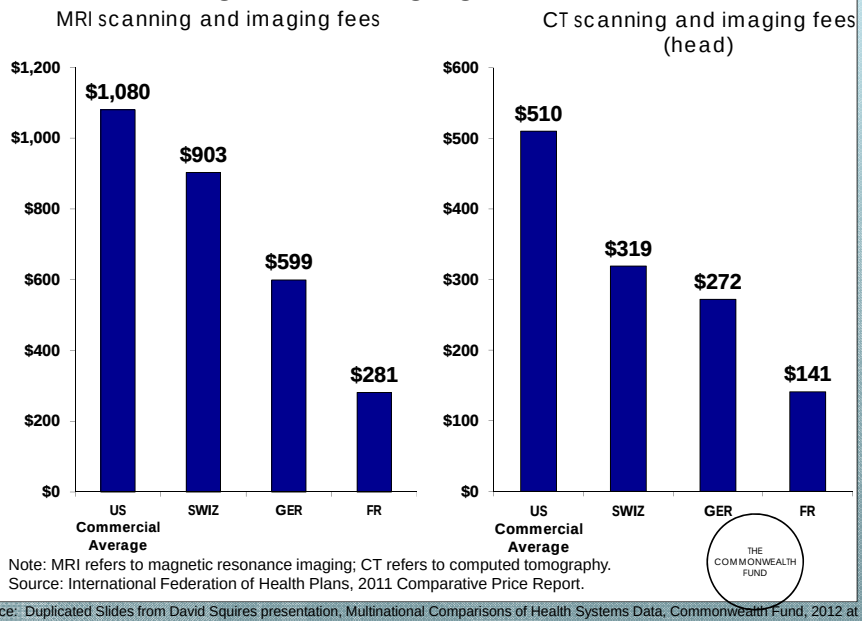
Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

129

Diagnostic Imaging Prices, 2011



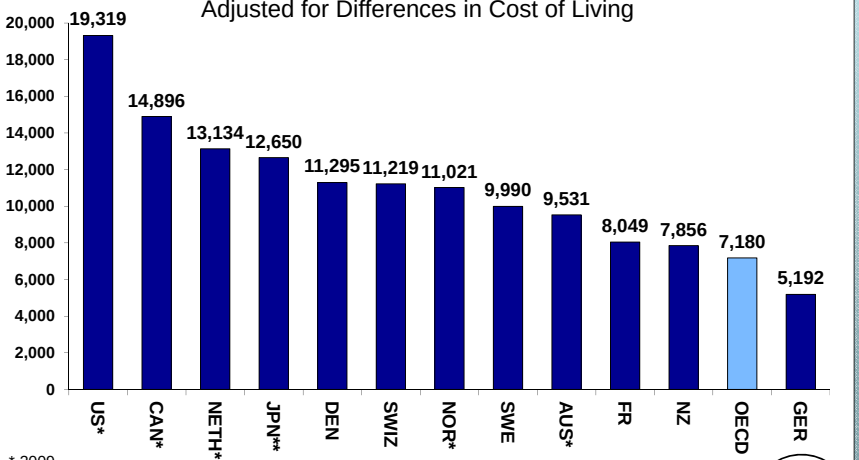
Note: MRI refers to magnetic resonance imaging; CT refers to computed tomography.
Source: International Federation of Health Plans, 2011 Comparative Price Report.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

130

Hospital Spending per Discharge, 2010

Adjusted for Differences in Cost of Living



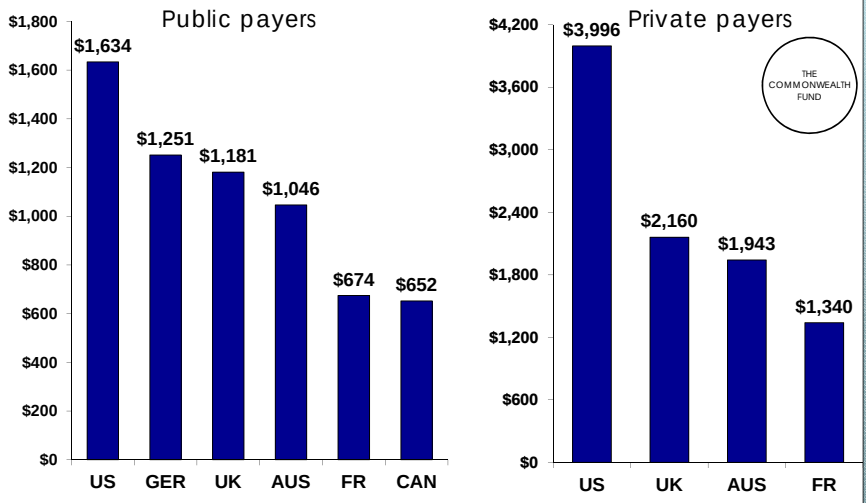
* 2009.
** 2008.
Source: OECD Health Data 2012.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

131

Physician Fee for Hip Replacement, 2008

Adjusted for Differences in Cost of Living



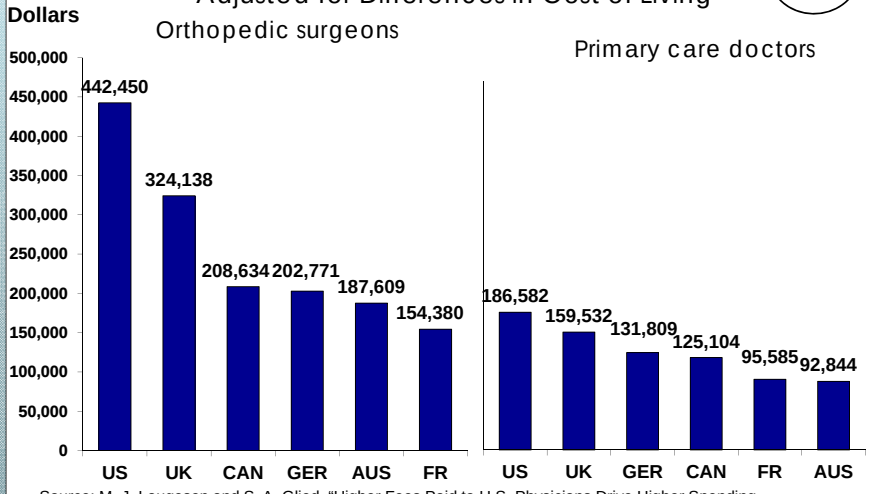
Source: M. J. Laugesen and S. A. Glied, "Higher Fees Paid to U.S. Physicians Drive Higher Spending for Physician Services Compared to Other Countries," *Health Affairs,* Sept. 2011 30(9):1647–56.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx

132

Physician Incomes, 2008

Adjusted for Differences in Cost of Living



Source: M. J. Laugesen and S. A. Glied, "Higher Fees Paid to U.S. Physicians Drive Higher Spending for Physician Services Compared to Other Countries," *Health Affairs,* Sept. 2011 30(9):1647–56.

Source: Duplicated Slides from David Squires presentation, Multinational Comparisons of Health Systems Data, Commonwealth Fund, 2012 at http://www.commonwealthfund.org/Publications/Chartbooks/2013/Mar/Multinational-Comparisons-of-Health-Data-2012.aspx