Part I: The Problem And The Challenge

Preface

Nothing so threatens the American public's access to health care services or the quality of these services as the cost of the services themselves. Cost is to health care what carbon dioxide is to global warming: it is the up-swelling ingredient that, if left unchecked, is the undoing of the whole system.

There is a long history of awareness in the country of this problem and an equally long history of ineffective attempts to deal with it. This is because there are forces at play that make steadily rising costs extremely difficult to hold in check. These include Americans' lifestyle choices and the consequent rise of chronic disease often resulting from these choices. The CareFirst service region is no different.

This, in turn, unleashes demand forces for health care services that meet a system of health care financing that thrives on volume. More units of service mean more revenue for providers who rationally act to meet the demand forces with higher volume – particularly of hospital-based services. The CareFirst region is especially remarkable in this respect.

Additionally, the fragmentation of the health care system through which Members must navigate leads to inevitable breakdowns, lack of coordination, duplication and miscues. Yet the freedom to choose from a vast array of providers is a cherished American value. Indeed, the HMO movement – once seen as the answer – has been limited in its growth by the unwillingness of the public to subordinate their free choice of provider to a single, organized, integrated system of care that they appear not to fully trust even when it provides high quality services.

Payer intrusion into the care giving process through medical review and preauthorization of services or through the creation of a maze of rules that thwart, confuse and block access has been unable to stem the rise, and instead has frustrated the public, providers and government officials alike.

The move toward shifting far more cost to individuals through high deductible plans – a move that has accelerated as a result of requirements of the Affordable Care (ACA) – has thwarted access to needed care and services – leading over the long term to breakdowns that become costly to address downstream.

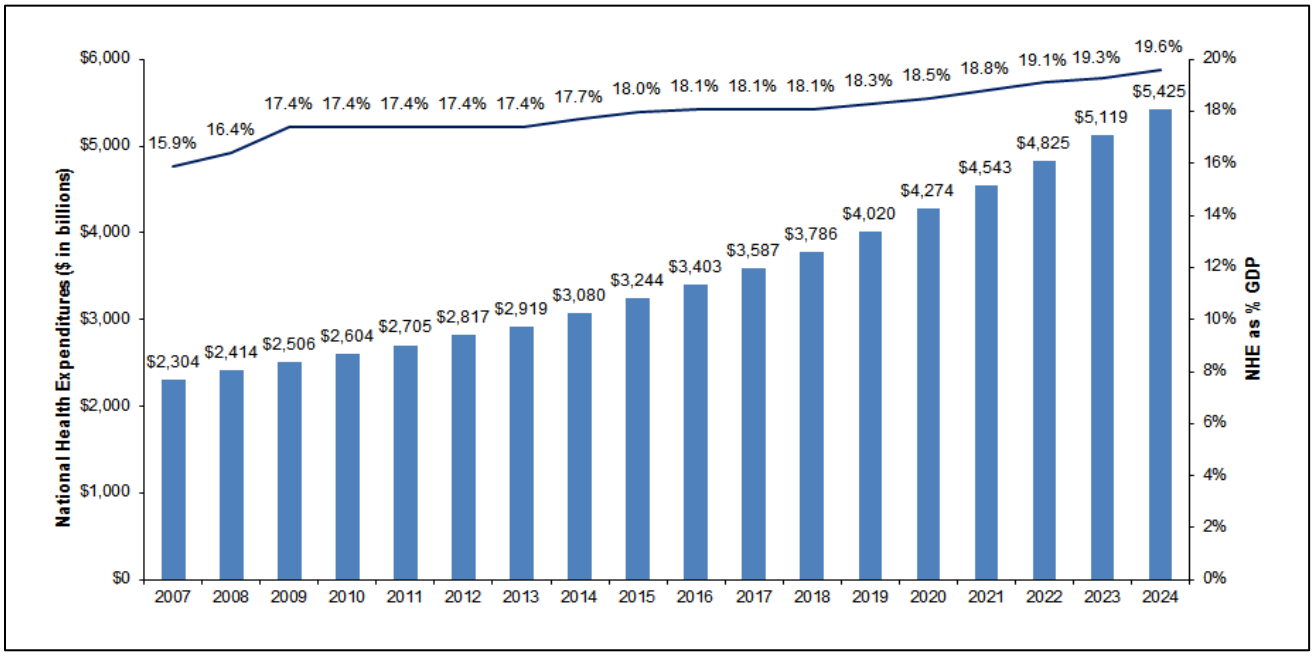
So, it is clear that the problem and challenge of controlling the rise in health care costs is daunting. Yet, failure to do so threatens the whole system. What one does to address the challenge is based very heavily on how the challenge itself is diagnosed and understood. This **Part I** presents CareFirst's analysis of the challenge and of previous attempts – including its own – to deal with this challenge. The PCMH and TCCI Programs derive their content and structure from this analysis.

Cost Is The Problem – Key Facts And Trends – National And Regional

The high cost of health care is the single greatest threat to access. If unabated, it threatens to place needed services out of reach for more and more people. It threatens the quality of services. And, it threatens the viability of providers.

As a percentage of the Gross Domestic Product (GDP), health care expenditures have risen from 15.9 percent in 2007 to 17.4 percent in 2010, and are on course to reach well over 18 percent by 2020 as shown in **Figure 1** below**.**

Part I, Figure 1: National Health Expenditure (NHE) Total Cost And Share Of GDP, 2007-2023[1]



Nationally, the rise in health care expenditures is expected to be in the five to seven percent range per year over the next decade if no effective actions are taken to abate it **(Figure 2),** although some recent slowing in trend has been observed. Nevertheless, health costs are likely to outstrip the expected rise in wages and general inflation by a considerable margin. However, since the recession of 2009-2010, it should be noted that there has been a sharp abatement in the rise of overall medical costs.

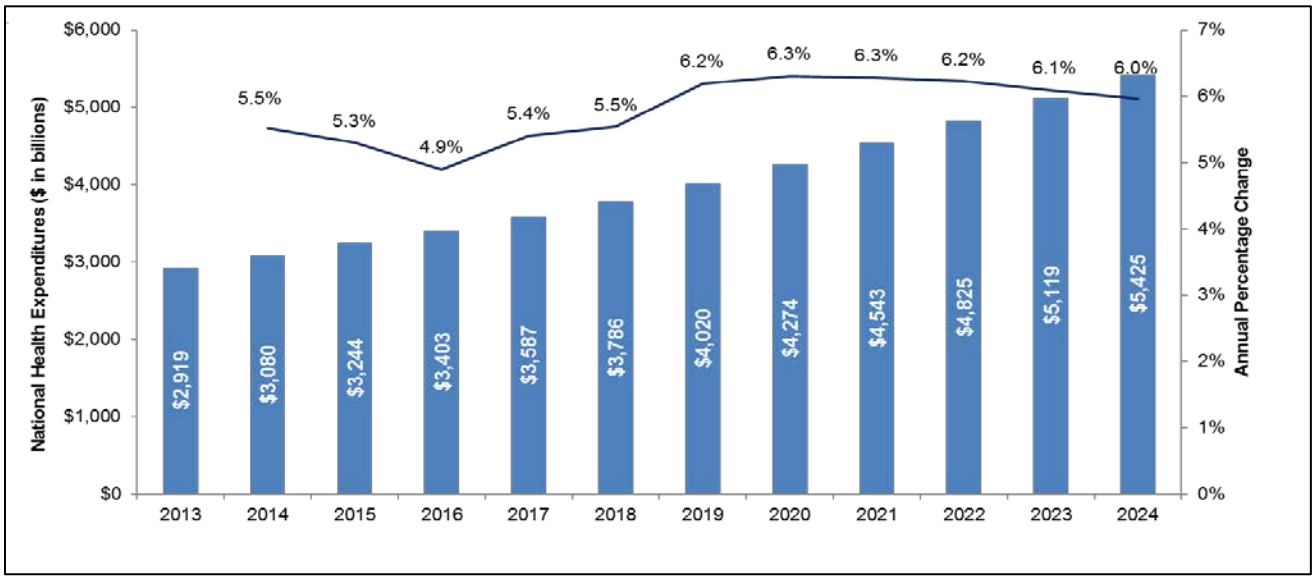
The cost of coverage for an average family of four covered by CareFirst for the most common Preferred Provider Organization (PPO) benefit plan is now about $1,700 per month. If one reflects on the fact that costs are projected to rise through the end of this decade at the pace shown, who then will be able to afford coverage if costs reach $2,500 per month or more? What, then, will be the concerns with access to quality health care services?

As can be seen in **Figure 2** on the next page, the yearly rate of rise in health care spending is expected to proceed at a steady pace over the next several years. There are some factors that many believe might cause it to rise more quickly – such as the aging of the population and pent up need for care from the newly insured, less healthy population who have been able to obtain coverage as a result of ACA. Even at the pace shown, health expenditures will rise over 60 percent in the next eight years if the trends materialize as depicted. This will almost certainly place full health coverage out of the reach of most people in the CareFirst region, assuming wages rise at even half the rate of health care costs.

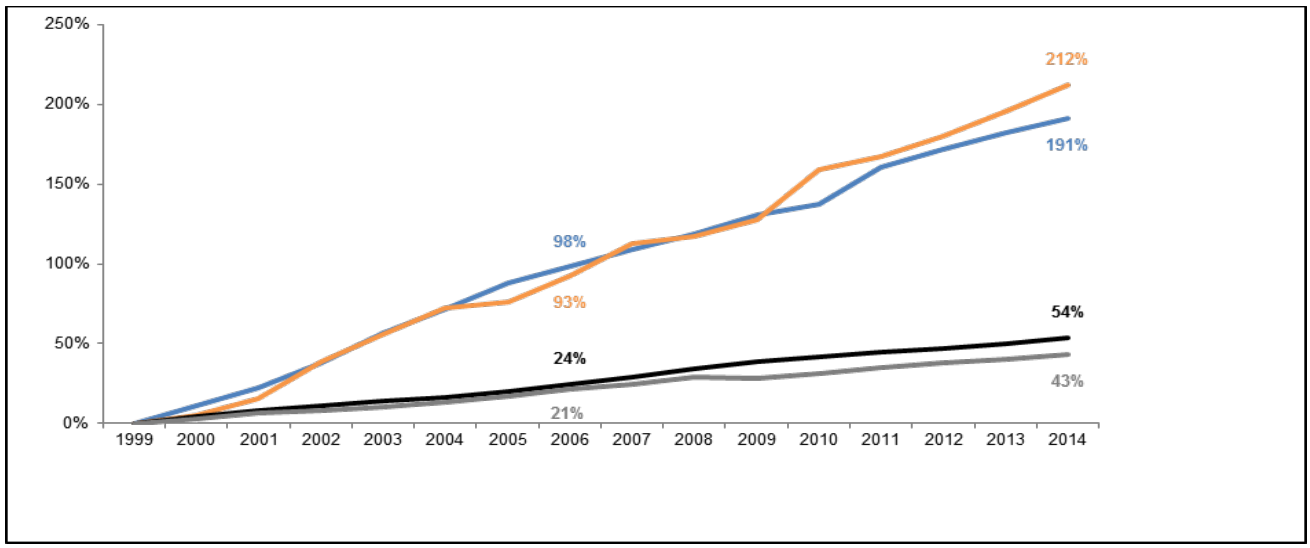
[1] *Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, NHE Web Tables, July 2015.*

When the rise in health care costs is shown in relation to the rise in wages and general inflation, the full cumulative impact can be seen clearly as shown in **Figure 3** below.

Part I, Figure 2: Projected National Health Expenditure (NHE), Calendar Years 2013-2024[2]



Part I, Figure 3: Cumulative Increases In Health Insurance Premiums, Workers' Earnings And Inflation, 1999-2014[3]



It is important to understand that Medical Consumer Price Index (CPI) in the CareFirst region has closely tracked the rate of increase in national Medical CPI. Medical CPI reflects the movement in unit prices of medical services such as the price of particular services, tests and equipment.

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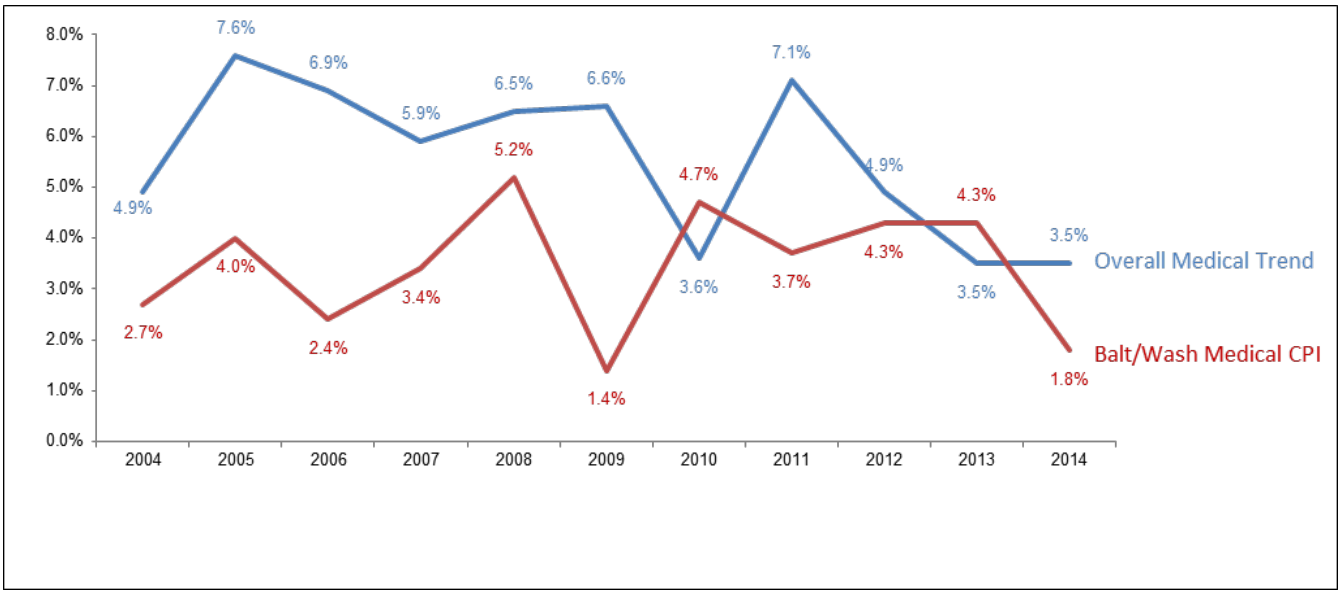
[2] *Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, NHE Web Tables, July 2015.*

[3] *Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2014; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment StatisticsSurvey,1999-2014 (April to April).*

A better measure is Overall Medical Trend (OMT) (see **Appendix E** for more on OMT) that measures both the change in unit prices (fees, rates) as well as the changes in use and mix of services. It is a more complete measure of the change in overall medical costs. Since Medical CPI assumes change in neither the number of services or in the mix of services, it has historically been lower than OMT.

As will be discussed throughout these Program Guidelines, use of health care services has been rising steadily, driven largely by demographics, expansion of coverage to previously uninsured individuals as a result of ACA, increased use of new technologies and the rise of chronic disease in the general population often reflective of American lifestyles. This is the key cause of the difference between OMT and Medical CPI shown in **Figure 4** below.

Part I, Figure 4: Historical CareFirst Overall Medical Trend (OMT) And Baltimore/Washington Medical Consumer Price Index (CPI)[4]



At the present time, the region served by CareFirst experiences per capita health care expenditures that are among the highest in the nation. These expenditures have been rising on pace with national trends.

The underlying reasons for cost growth must be understood and dealt with if there is to be any hope of avoiding the looming crisis. This will require changes to American lifestyles as well as in the way health care services are organized, financed and supported.

The idea that health insurance reform under the Affordable Care Act – by itself – is enough to deal with the problem of escalating costs is rejected here. In fact, implementation of the centerpiece of federal health care reform in 2014 – guaranteed issue coverage plans coupled with an individual mandate and supported by low income premium and cost sharing subsidies for a large part of the population –is showing evidence of inducing further unaffordable demands on a system of health care financing that is fundamentally not conducive to cost control as it presently exists.

[4] *Source: Bureau of Labor Statistics, Consumer Price Index (CPI), 2004-2014; CareFirst Actuarial Department, 2014.*

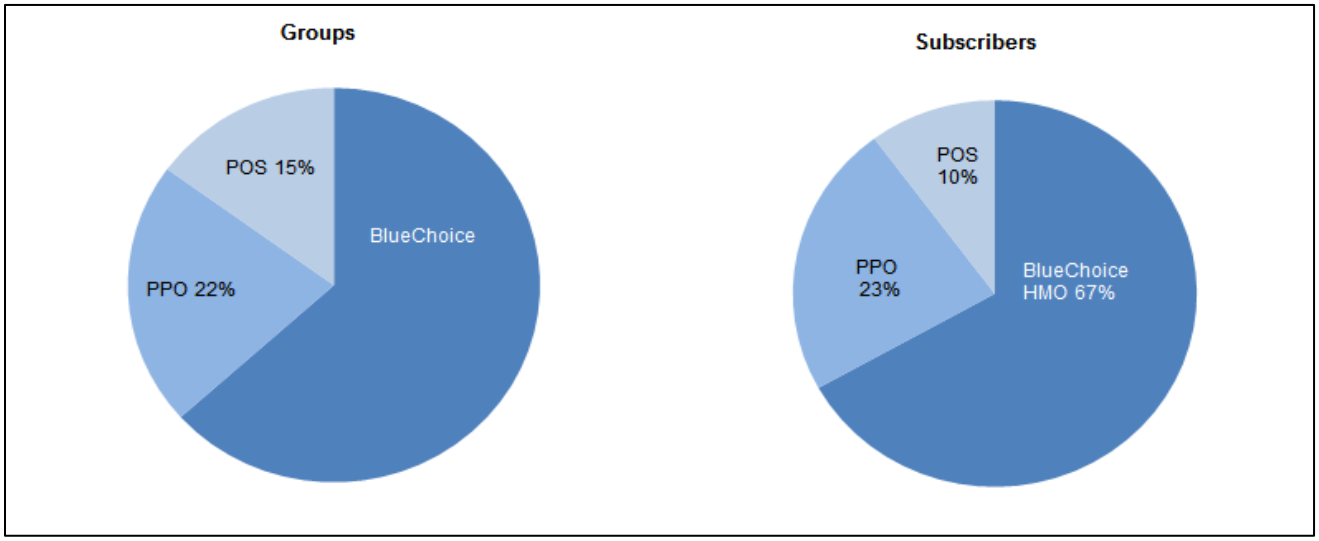
Benefit Design/Plan Coverage Changes Are Not Enough

To underscore the point that plan coverage changes by themselves are not enough, consider the fact that new coverage designs aimed at controlling costs were massively introduced into the CareFirst service region over the latter half of the last decade with the launch and rapid market adoption of high deductible health plans (HDHPs). High deductible health plans have become even more prevalent recently with the requirement that all ACA Qualified Health Plans in the Individual and Small Group markets must meet specific actuarial values as defined for the metal levels that dictate Member cost-sharing. Bronze and Silver plans typically have deductibles of several thousand dollars or more. Moreover, medium and large employer groups have broadly embraced HDHPs in order to control their premium (if fully-insured) or medical care costs (if self-insured) expenditures.

The cost trends emerging from these high deductible coverage plan designs show how difficult it is to control cost growth using changes in coverage plans as the only strategy.

High deductible designs are often accompanied by a Health Reimbursement Account (HRA) or a Health Savings Account (HSA). But, experience has shown that only two-thirds of HSA accounts are funded by employers and that primary care services are subject to substantial deductibles, with the exception of preventive services. Most CareFirst high deductible products are offered through the BlueChoice (HMO) product portfolio, as shown in **Figure 5** below.

Part I, Figure 5: CareFirst Maryland Small Group High Deductible Enrollment, May 2015[5]



CareFirst initially introduced these high deductible designs in mid-2006 in response to employer demand for less expensive alternatives and in deference to the emerging idea that sensitizing consumers to costs – by shifting more cost to them – would work to control costs over the long term. The premise was that these plan designs would make consumers more judicious "buyers" of health services. In late 2006, these plan designs accounted for approximately seven percent of CareFirst enrollment in the Maryland small group market as shown in **Figure 6** and **Figure 7** on the next page.

By mid-2015, 63 percent of CareFirst's Maryland small employer group subscribers were enrolled in these designs – principally because they carry substantially lower premiums. The result is that employers have shifted more costs to employees and reduced their benefits, a process known as "benefit buy-down." During the 2007-2011 period alone, employers "bought down" their benefits by more than 10 percent cumulatively through ever higher deductibles and cost-sharing. In the process, they shifted over one billion in health care expenses to their employees and dependents.

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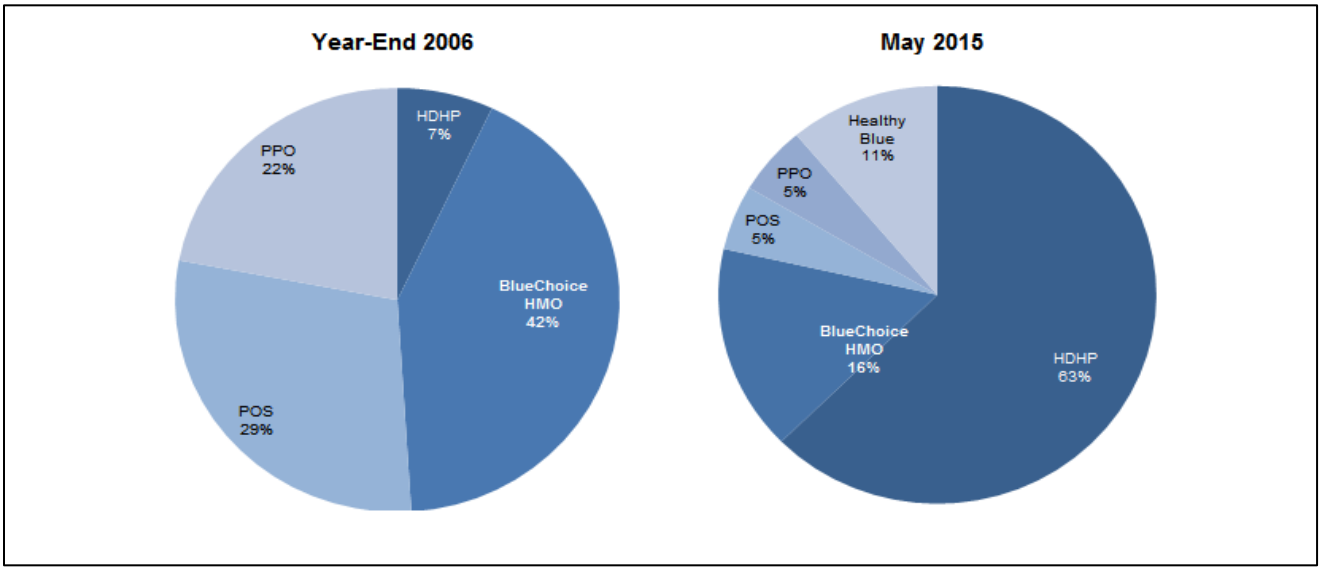
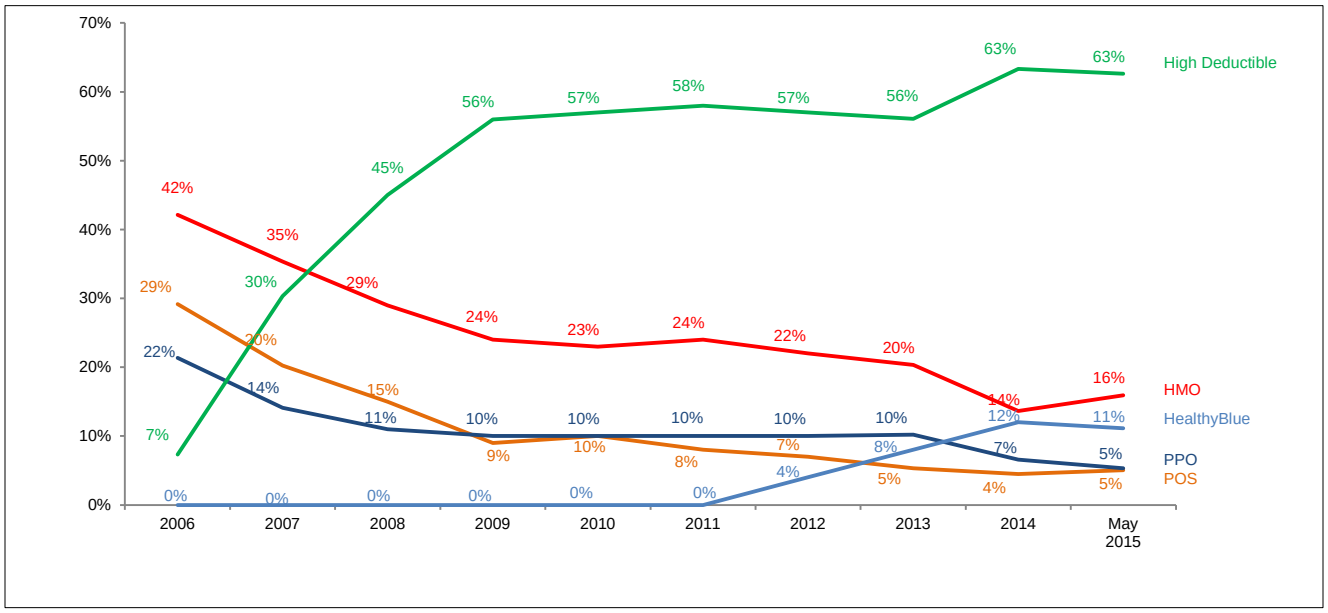
[5] *Source: CareFirst Enrollment Report (CER), May 2015.*

Part I, Figure 6: CareFirst Maryland Small Group Product Distribution, 2006 vs. 2015[6]



A depiction of the massive market shift to high deductible health plan designs is shown on **Figure 7** below.

Part I, Figure 7: CareFirst Maryland Small Group Product Distribution Of Total Enrollment, 2006-2015[7]



The central concern with the cost shift caused by high deductible plans is that Members may delay seeking care or not get care at all – both of which will likely have negative future effects. This shift also decreases the perceived value of coverage by Members – because they directly bear more cost themselves and because the designs are more complicated to understand and administer. The central idea behind these designs was that they would encourage people to become more careful consumers of health care services. There is little evidence this has occurred.

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[6] *Source: CareFirst Enrollment Report, December 2006 (UER), May 2015 (CER).*

[7] *Source: CareFirst Corporate Enrollment Report (CER), Dec 2006-May 2015.*

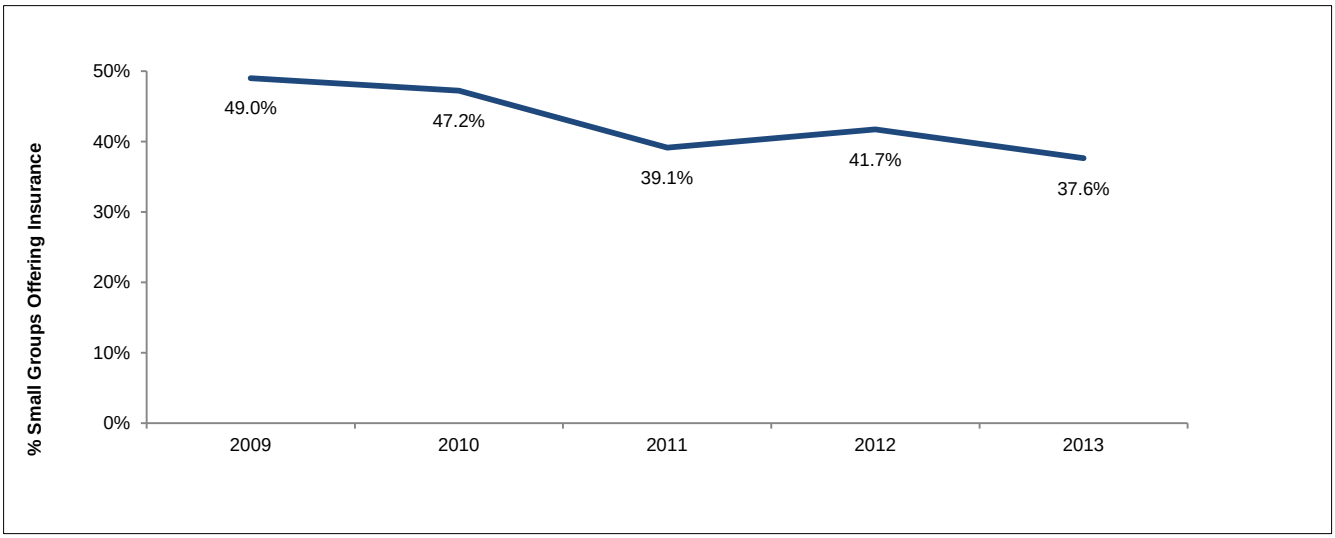
In addition, these designs may lead to increased receivable and collection problems for providers who now have much more to collect from Members when they seek care.

Although the pace of the upward march of health care cost trends has slowed recently, the causes of this slow down are not well understood. In the meantime, we may be nearing a level of cost shift that is not affordable for Members, while the percentage of small employers not offering coverage at all continues to climb.

In essence, what seems to be happening is that small employers first introduce high deductibles to limit cost and then drop coverage altogether when even these designs become unaffordable. As of 2013, two-thirds of all small employers in Maryland did not offer coverage at all. Of the third left with coverage, the vast majority have coverage through CareFirst. And, among these CareFirst small groups, nearly two-thirds of them, in turn, offer only high deductible health plan options.

Figure 8 below illustrates these disturbing trends.

Part I, Figure 8: CareFirst Maryland Small Group Health Benefit Plan Participation, 2009-2013



As noted previously, many plan designs required by ACA have very substantial cost-sharing provisions. For example, Bronze and Silver metal level plans contain 40 percent and 30 percent Member cost-sharing, respectively, which translates into $1,350 to $6,550 in deductibles and out-of-pocket expense limits of $6,850 per year per person in 2016. Of all the Individual Members who enrolled in ACA coverage plans, over 70 percent enrolled in plans on these metal levels. The consequences are likely to be dire in terms of discouraging access to needed primary care and other services when illness strikes, particularly for those Members whose household incomes are not low enough to receive subsidies.

All of this has been driven by a single factor – cost.

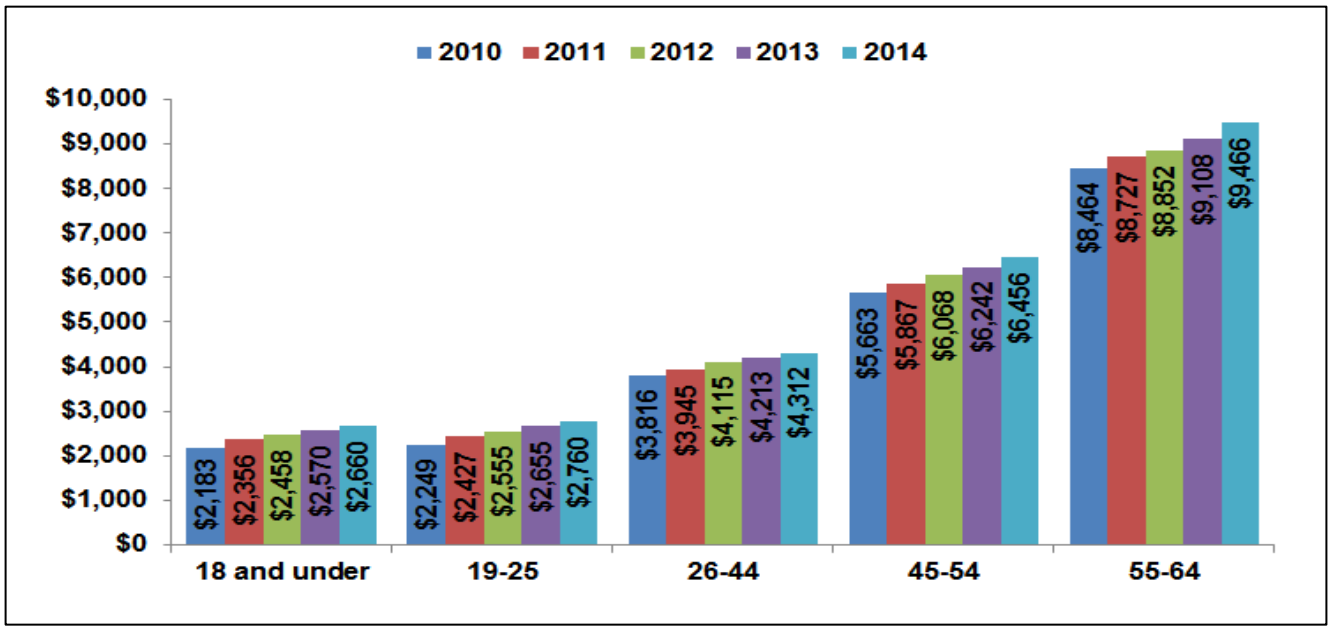
One final word about high deductible plans: Since a large percentage of total medical costs in any year are associated with a small number of people with acute or chronic illnesses who run up enormous health care bills, these costs typically far exceed even the highest deductible and other out-of-pocket cost limits that are included in high deductible plans. Therefore, a large share of the medical costs incurred by people covered by high deductible plans occurs after they have exceeded the out-of-pocket limits that are set by these plans. Further, this care involves complex tests, procedures and drug regimens that they are in no position to question or "shop" for best prices.

That is, even if those covered by these plans had an ongoing interest in their medical expenses, it is questionable whether persons who are gravely ill have the ability to purchase care on a cost-effective basis for themselves. Hence, these plans are not likely to represent – by themselves – the path forward toward more effective cost control.

Demographics Are A Leading Cause Of Cost Growth

Meanwhile, demographics of an aging population are a leading cause of cost growth. As the population ages, higher health care costs are inevitable, as seen on **Figure 9** below. This is a virtual demographic certainty.

Part I, Figure 9: Per Capita Health Expenditures By Age, 2010 vs. 2014[8]

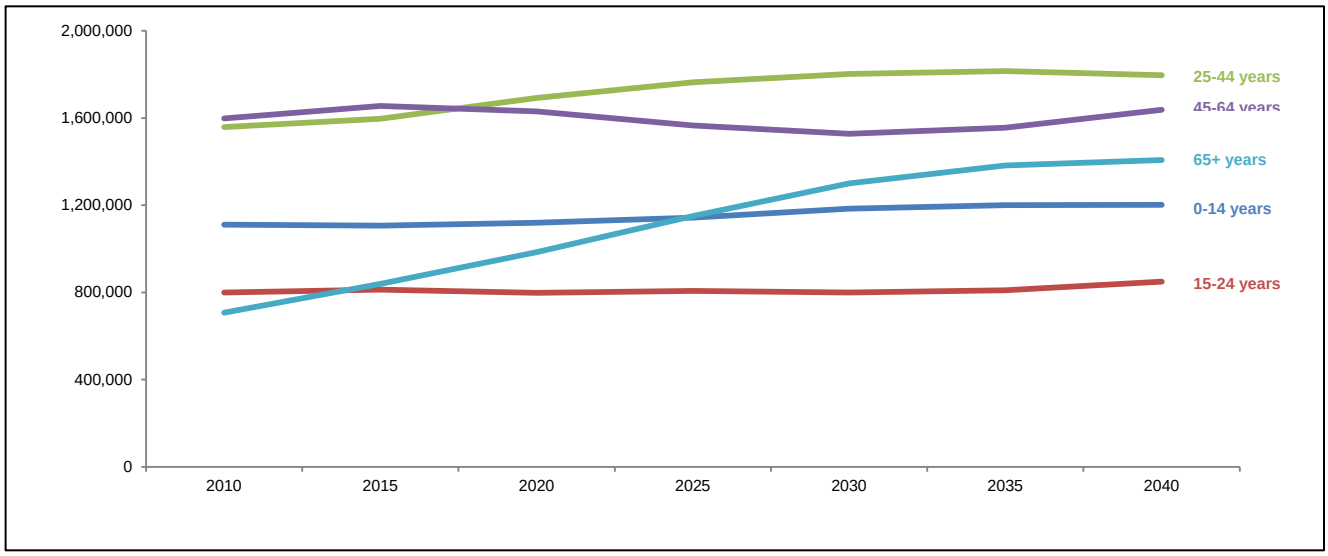


From 1980 to 2014, the total population of Maryland and the District of Columbia increased from 4.8 million to 6.6 million, representing an average annual growth rate of 1.1 percent During the same period, the number of 45 to 64 year olds increased 2.4 percent per year, increasing from 977,000 to 1.8 million and the population of individuals 65 years of age and older grew 2.4 percent per year, increasing from 470,000 to 868,000.

Total population growth in the CareFirst service area from 2010 to 2030 is projected to increase by more than 800,000, with over 70 percent of the growth coming from the 65+ group as depicted in **Figure 10** on the next page. Absent any lifestyle influences, health care costs would be expected to increase by virtue of absolute population growth and aging alone. These forces – in combination – drive increases of about one to two percent per year.

[8] *Source: Health Care Cost Institute, Health Care Cost and Utilization Report, 2014.*

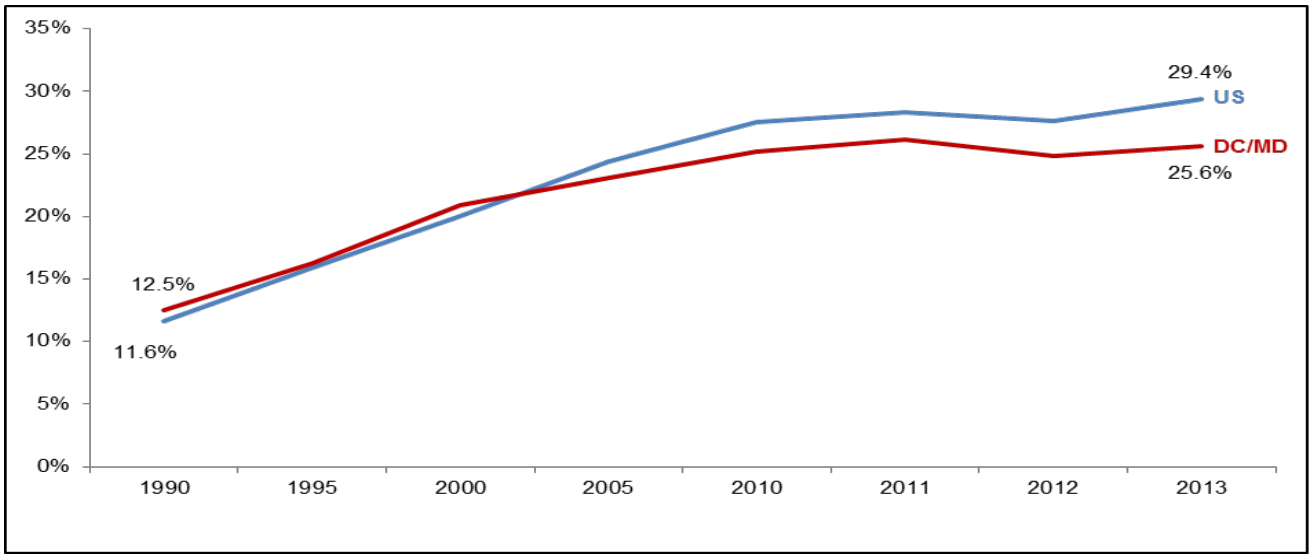
Part I, Figure 10: Resident Population, Maryland By Age (For Selected Years)[9]



Lifestyle Has Exacerbated Demographic Trends Toward Higher Health Care Use

The impact of this aging phenomenon on rising health care costs has been further accelerated by the consequences of American lifestyles and habits. Obesity has become the central pervasive problem. The prevalence of obesity in the CareFirst region has increased over 130 percent since 1990 (see **Figure 11)** and has brought with it all the related maladies of cardiovascular disease, diabetes, stroke risk, etc. This mirrors the national experience.

Part I, Figure 11: Prevalence of Obesity, U.S. vs. DC/MD Region (For Selected Years)[10]



The prevalence of chronic disease in the nation can be seen in **Figure 12** on the following page. Slightly more than half of the population has at least one chronic condition with the prevalence of chronic conditions increasing dramatically with age as shown in **Figure 13** also on the following page.

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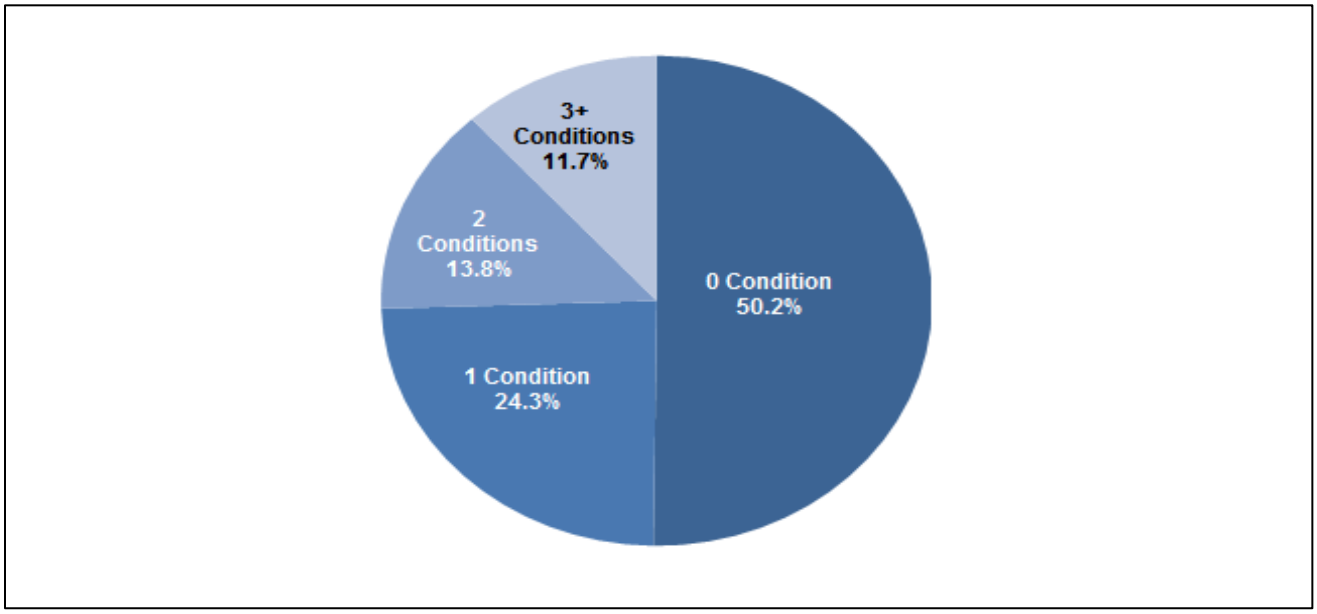
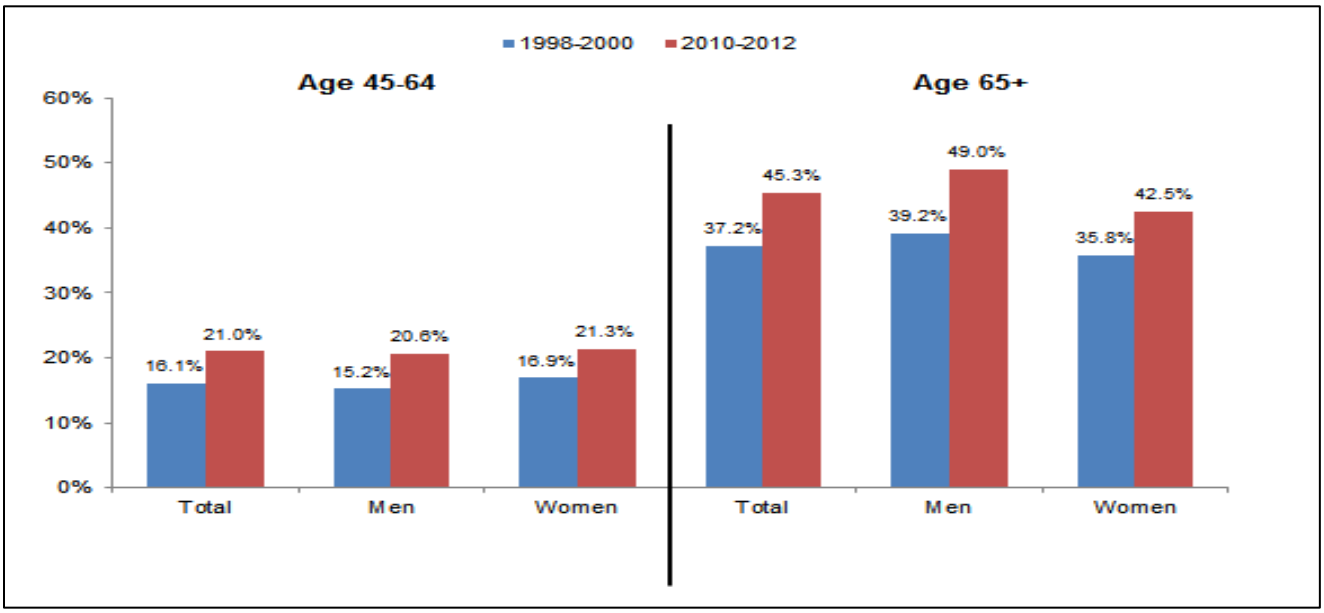
[9] *Source: Maryland State Department of Planning. 2014 Total Population Projections by Age. Revised January, 2015.*

[10] *Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System Survey Data.*

Part I, Figure 12: Prevalence Of Chronic Conditions Among Adults, 2012[11]



Part I, Figure 13: Prevalence Of Two Or More Chronic Conditions Among Adults, 2012[12]



[11] *Chronic conditions include hypertension, coronary heart disease, stroke, diabetes, cancer, arthritis, hepatitis, weak or failing kidneys, chronic obstructive pulmonary disease, or current asthma.*

Source: Ward BW, Schiller JS, Goodman RA. Multiple Chronic Conditions Among US Adults: A 2012 Update. Prev Chronic Dis 2014; 11:130389. DOI: http/dx.doi.org/10.5888/pcd11.130389.

[12] *Chronic conditions include hypertension, heart disease, diabetes, cancer, stroke, chronic bronchitis, emphysema, current asthma, and kidney disease. 2009-2010 results were significantly different from 1999-2000, $p < 0.05$.*

Source: Centers for Disease Control and Prevention (CDC). National Health Interview Survey.

As a consequence, by some estimates, three-quarters of total health spending in the U.S. is caused directly or indirectly by chronic disease[13] – not for just one, but multiple chronic diseases that have a tendency to exist together in a single individual.

Worse, the markers for chronic disease are becoming more pervasive in younger population segments. Approximately one-third of children in the U.S. are overweight and nearly one in five is obese[14]. The percentage of children in these categories has been rising over the past three decades (with some recent slowing). This brings with it the likelihood of a long list of maladies that cluster around obesity, including high blood pressure, diabetes, cardiovascular disease and more. The markers for these maladies are now increasingly appearing in children as young as ten years old. As if this were not enough, babies are being delivered by mothers who are themselves obese, presenting risks for both mother and baby. A recent New York study[15] found that nearly four in ten mothers who gave birth in recent years in urban hospitals were obese.

Many people react to the consequences of chronic disease with a "fix me" attitude. That is, many people see medical intervention – not change in lifestyle – as the answer. The thought is that a lifestyle based on inexpensive, processed fast food consumed in supersized portions together with sedentary habits need not be changed if a drug or medical intervention can remedy or mitigate the health downsides. Indeed, the impact of better medical technology and knowledge has been to facilitate just this thought process and to keep people with multiple chronic diseases alive and functioning longer – at persistently higher cost – with ongoing and cumulative health problems.

Huge Unmet Need Remains

The amount of unsatisfied demand for health services is huge because much chronic disease goes untreated or undertreated. There is also compelling evidence that even those in treatment often do not comply with their medical or pharmaceutical treatment protocols. Indeed, a number of studies have shown that compliance is as low as 30 to 50 percent with prescription medication – let alone more extensive Care Plans.

Additionally, gaps in care for the portion of the population with chronic disease(s) are exceedingly common due to the fragmented nature of the health care system itself. The treatment of chronic disease – particularly multiple chronic diseases in a single Member – often involves multiple specialists and other care-givers over an extended period of time. Often, Members fend for themselves in trying to access and coordinate the services they need. Understandably, they do this very imperfectly. Care sporadically obtained in an uncoordinated way over long periods of time sub-optimizes outcomes. Yet, this is the norm.

Studies performed by the RAND Corporation[16] have shown that Americans receive only about 50 percent of the "appropriate" care they should get – according to well-documented and broadly endorsed clinical guidelines – for a range of common conditions. Thus, even though there is much evidence of significant overuse of tests, procedures and other types of care, there are also large areas of clinical practice where more care of an appropriate nature is needed.

Illness Burden And The Illness Burden Pyramid Of Costs

To put the impact of chronic disease in perspective, CareFirst continually analyzes its claims experience and finds that a small percentage of its Members – those with advanced manifestations of multiple chronic diseases – consume approximately half of all of the Company's health care spending in the region. This mirrors the national experience. There can be no moderation in health care cost increases without recognizing this problem and squarely dealing with it.

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[13] *The Partnership to Fight Chronic Disease, 2009 Almanac of Chronic Disease: The Impact of Chronic Disease on Health and Prosperity; A Collection of Statistics and Commentary.*

[14] *Bethell, Christina, et.al., National, State, and Local Disparities in Childhood Obesity, Health Affairs, March 2010, Vol. 29, no. 3, healthaffairs.org.*

[15] *Growing Obesity Increases Perils of Childbearing," New York Times, June 5, 2010.*

[16] *Landmark Study Finds American Adults Often Fail to Get Recommended Care, Posing "Serious Threats" to Health, The RAND Corporation, 25 June 2003, http://www.rand.org/news/press/2003/06/25.html.*

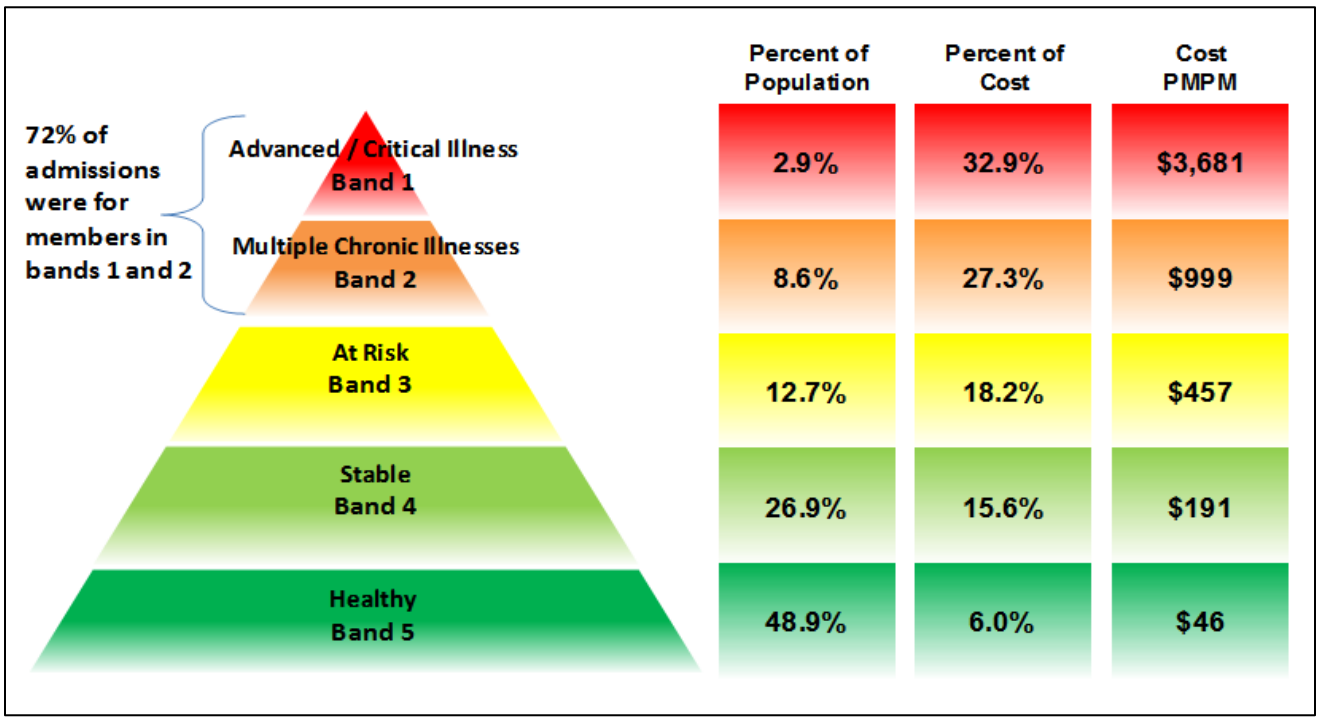
CareFirst calculates an Illness Burden Score for each Member it serves every month based on the Member's unique claims history using the trailing 12 months of claims experience for each Member. This score shows not only the relative current illness level of the Member, but is useful in determining which cohorts of Members are most likely to have high future costs. When Members with "like" illnesses are pooled together, in bands, such as those shown in the pyramid below, one gains a perspective on how the Illness Burden – the degree of illness or the risk for future illness – influences cost patterns in a population of people.

This is vividly illustrated by the "Illness Burden Pyramid" that is familiar to anyone with experience in the health insurance field. As can be seen in **Figure 14** below, the top three percent of CareFirst Members – typically those with acute, catastrophic or end-of-life conditions – accounted for 33 percent of total medical care payments by CareFirst based on 2015 data.

The next nine percent of Members – typically those with multiple chronic diseases in advanced stages – account for another 27 percent of total medical care payments. It is noteworthy that the bottom 49 percent of Members account for only six percent of total medical care spending. This pyramid is consistent in all age 65 and under populations in all markets in the United States.

It is stunning to consider that the cost PMPM of those in Band 1 is 80 times higher than for those in Band 5. Band 1 Members have Illness Burden Scores that range from five to 50 times the average in the community as a whole while Band 5 Members have one-fifth the average Illness Burden of the community average.

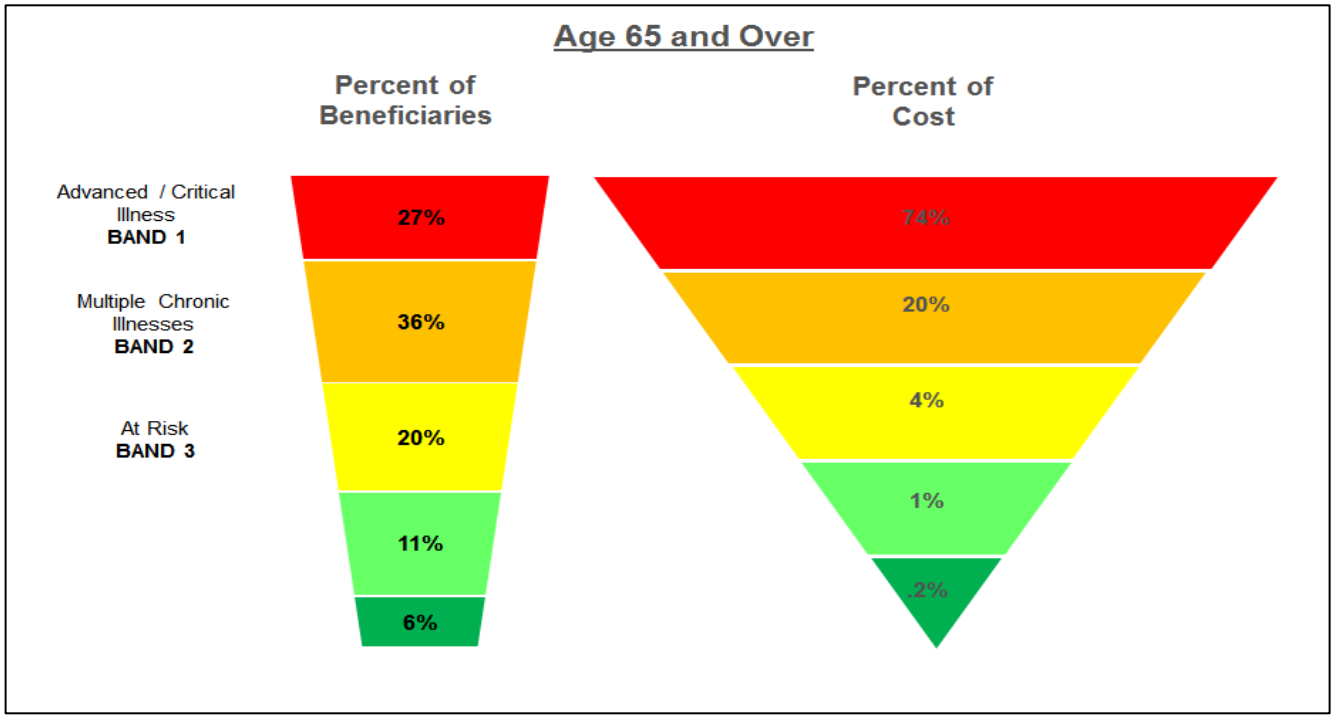
Part I, Figure 14: CareFirst Illness Burden Pyramid, 2014[17]



A very different picture of the Illness Burden Pyramid emerges when looking at the Medicare FFS beneficiary population. This is shown in **Figure 15** on the next page. The Medicare population is filled with the full flowering of chronic disease brought on by both advancing age and the cumulative effect of lifestyle habits. For every one dollar spent on health care services per person in the under age 65 population, Medicare spends approximately four dollars.

[17] *Source: CareFirst HealthCare Analytics – Incurred in 2014 and paid through March 2015 – CareFirst Book of Business, excluding Medicare Primary Members.*

Part I, Figure 15: Medicare Fee-For-Service (FFS) Illness Burden Pyramid[18]



Defensive Medicine Plays A Role In Cost Patterns

To understand costs more fully, one must add to this pattern in any population, the cost impacts of defensive medicine and the concern that physicians feel that their failure to order or conduct extensive testing may subject them to malpractice risk. If confronted with something out of the ordinary, most PCPs or NPs refer to specialists who then often become the most critical medical decision maker for the Member on only the particular aspect of the Member's condition that is within the scope of their practice. A holistic view of the Member is often not gained.

Members frequently demand testing beyond what may be necessary to be sure of a diagnosis or to rule out certain conditions and diagnoses. Members also often demand prescription medications to treat conditions that the PCP believes may be better addressed through other approaches. PCPs are placed in a difficult position if they resist this pressure.

All of these forces persistently push up demand for service with no sign of abatement. As far as one can see into the future, it appears that greater demand is coming. Indeed, as already noted, if one looks to younger generations, there is nothing encouraging in the data about lifestyle and its coming consequences.

Here is the disturbing conclusion: CareFirst, as a payer, and we, as a society, face a tsunami of demand just as benefits are being curtailed due to lack of affordability. The market shift to high deductible plans is the first manifestation of this as is the failure to offer coverage or the dropping of all coverage by a clear majority of small employers. And, the substantially lower premium prices in the Individual market in Maryland for similar benefit coverage plans under ACA further spurred more small groups to drop coverage. The plan designs offered under the Affordable Care Act on each of the various metal levels – particularly on the Bronze and Silver levels – have very large amounts of cost-sharing in them, as already noted. Even Members with substantial subsidies are left with considerable cost-sharing. What behaviors will this cause? Are we headed to a solution? Not by ACA insurance reforms alone.

[18] *Source: CareFirst HealthCare Analytics –Incurred in 2014 and paid through March 2015 – CMMI Grant Data for Medicare Beneficiaries.*

Powerful Demand Meets A Fee-For-Service (FFS) System That Rewards Volume

If all of this were not enough, the system of health care financing in this region – like most of the nation – is based on an inherently inflationary model since it relies almost exclusively on a FFS method of payment. This system builds in powerful forces for growth in the volume of service. It is no surprise that when one pays by unit, one gets more units.

The vast majority of providers are paid in this way – by government Programs (e.g., Medicare) as well as private insurance carriers, such as CareFirst. This includes payments to physicians, hospitals, pharmacies, physical therapists and virtually all other providers.

This has led to a determined payer focus on trying to limit fee levels (unit price) with Medicare setting the framework and benchmarks. Unit price has been the object of a large consultant community that pores over the relative fees paid by different carriers. As payers try to control unit fees through contracted provider networks, the volume of service rises steadily – at least, in part, to compensate for fee/rate restraints.

It is now clear that federal health care reform depends on major Medicare savings in the form of fee and rate restraints to providers in order to cover the costs of increased coverage to millions more Americans and the subsidies this entails.

While hospital unit charges in Maryland are controlled by State regulation, the one-third of all health care costs that are driven by professional fees (two-thirds of which, in turn, are for physician services) are not regulated and never have been. Therefore, control rests with the private contracting efforts of payers who develop – as CareFirst has – networks of providers who accept less than their billed charges as full payment. If this were not true, payments to physicians would be two to three times higher than their current levels – and premiums would be substantially higher as well.

It is elemental to realize that efforts focused only on fee levels fail to address the key inflator – the high use of services driven by high demand – which is, in turn, driven by lifestyle and aging, and a financing system that rewards volume. A central reason why the CareFirst region experiences among the highest health care costs per capita of any region in the U.S. is the direct result of high use levels. The region has among the highest rates of hospital admissions, one day stays, readmissions and professional service use levels in the nation.

Why this is so is not well understood. There are no known, unique risk factors in the region driving this higher use level. But a number of experts believe that it was the reimbursement system itself – with its historical emphasis on volume based rewards – that induced higher use. The new all payer system of hospital reimbursement is designed to contain and reverse this under Maryland's new Medicare waiver that went into effect on January 1, 2014.

Under Phase 1 of the new waiver, Maryland has transitioned to a population-based model where hospital revenue is no longer impacted as directly by volumes, but is adjusted based on population and demographic factors. An expected outcome of the new waiver is that hospital admission/readmission and utilization rates should come down to national norms. This will not happen overnight and is likely to take the full five years allowed under the waiver to reach national averages.

Despite the challenges and volume inducing aspects of FFS payment, many believe that PCPs are substantially underpaid in the aggregate while specialists, particularly hospital-based specialists, are overpaid relative to PCPs. It is believed that this is leading to imbalances and shortages in the availability of primary care services – the key to accessibility.

Nevertheless, there is little evidence that the region served by CareFirst has a greater undersupply of physicians or a greater shortage of PCPs and NPs than other regions of the country.

The need to generate income from the FFS system has led many PCPs and NPs to pass Members through their offices at high rates of speed – often at 35 or more Members a day. This has led to Member encounters of ten minutes or less with quick handoffs to specialists when anything beyond the routine is found – as noted above. Quite simply, there is little financial reason for a PCP and NP to take the time and risk or bear the consequences with more complicated Members in his/her office.

This forced, rapid-fire style of practice is often not what the PCP or NP wants. Most would prefer to work more closely and extensively with those of their Members who have multiple conditions to manage. This simply is not possible in a fee-based

system that pays solely based on visits, not on outcome or Member need. (It should be noted that Phase 2 of the new Maryland Medicare waiver – to begin in 2019, if approved – would include non-hospital costs, i.e., Medicare Part B).

Fragmentation, Gaps And Breakdowns Result From FFS System

Not surprisingly, as is evident to any user of health care services, the health care system that has been built by the FFS financing system is highly fragmented with silos of independent specialists and other practitioners. In such a system, coordinated care and shared information – the keys to better outcomes for people with chronic disease – are hard, if not impossible, to achieve.

To make matters worse, a person with multiple chronic diseases typically visits a number of specialists who have no connection to each other. Each focuses on his/her specialty. The busy PCP or NP is often not aware (or, at least not aware timely) of the outcome of these visits or of a subsequent hospital admission. Each provider cannot see or may not trust what the other has done and may repeat what the other did. No longitudinal Member record exists that displays all the services (and results) provided by the fragmented health care system to a particular Member.

Too often, real coordination of care does not occur. Indeed, many small primary care groups lack the capacity for Care Coordination because of limited resources and systems. And, nearly three-quarters of PCPs or NPs in the CareFirst service area practice in solo offices or in groups of fewer than three physicians.

No Holistic Picture Or Understanding Of Chronic Disease Members

The bottom line: one of the things most essential to the care of Members with chronic disease – a complete running understanding and record of their evolving condition and treatment – is most lacking. Thus, there is no holistic focus on outcome and results over time across providers, care settings and services.

Further, providers in the current FFS System of financing are not incented/rewarded to overcome this. Nor do providers typically see, understand or come to grips with the aggregate cost of services that the fragmented FFS system generates for such Members. This is a central problem that must be squarely dealt with if care cost trends are to be moderated.

Emergence Of Integrated Health Care Systems – Hope And Concern

It should be noted that a marked trend toward integrated systems of care is emerging in this country and region. These systems are almost always hospital-centric. In this region, we have seen the merger and/or affiliation of smaller community hospitals into larger academically-centered systems as has been true elsewhere. Increasingly, these large systems are employing physicians who were formerly in private practice as well as those just entering practice. Smaller, independent systems are in decline and may be largely gone by the end of this decade.

Two contradictory observations can be made about this: on the one hand, these large health systems offer the hope that badly needed integration will bring a pathway to help solve some of the problems of fragmentation. On the other, many experts are becoming increasingly concerned – as is CareFirst – that these consolidations represent oligopolies or monopolies that will breed a virulent new form of cost growth and unchecked negotiating power.

Additionally, massive capital investments made by hospitals in the last decade now cause an equally massive urgency to secure Member flow and volume. Almost without exception, the compensation systems used by integrated health care systems for newly employed physicians reward the generation of billings and little else.

It is almost perfectly true that the larger the integrated system, the higher the unit fees/rates they are paid. This reflects little more than the respective leverage of the parties involved and raises the legitimate concern that the larger these systems become, the higher their reimbursement becomes.

In this environment, an employed PCP or NP is seen by an integrated health care delivery system as an inlet valve – most useful for revenue preservation or enhancement through referrals to specialists in the larger system. Thus, the congealing health system generates its own demands that converge with the rising demands in the population and the demands prompted by FFS medicine and malpractice fears. This is a “witch’s brew” for a society concerned with the continued rise in health costs.

Current Forces Work Against Cost Control Even With Federal Reform

Given all of this, should we be concerned about future health care cost increases? Can there be a doubt of the answer? It is a resounding "yes." As a society, we have catalyzed potent forces that drive costs ever upward.

The intense federal health care reform debate and the final ACA legislation that became law does not focus on curtailing these forces anywhere near as much as it does on insurance reform. ACA has, however, spawned efforts to innovate and find new payment incentive and accountability models. Indeed, this feature of ACA led to the Innovation Award CareFirst received to bring Medicare FFS Beneficiaries into the PCMH/TCCI Program.

It must be said that the benefits of additional coverage under ACA will be short-lived if costs are not better controlled as time progresses. There is a desperate need for success in the new models being tested.

Long List Of Previous Approaches – Some Lessons Learned

Looking back over the past four decades, one is struck by the fact that substantial continuing efforts to curtail costs have been made – without substantial effect. What have we learned from these efforts that might guide us now?

To start, one needs only to recall the power of the movement that led to the creation of Health Maintenance Organizations (HMOs) that were the original hope for a more efficient care model to focus on prevention, wellness, holistic Member view, and Care Coordination. This hope was largely rooted in the belief that attention to the "whole" enrollee was needed. This was certainly not wrong. Yet, pure HMOs are a far smaller force today than were originally envisioned and have had generally less success and market appeal than was expected. Their typically closed or limited practice model has left a large percentage of the population looking for more choice.

A far different approach – aggressive payer intrusion into the care-giving process through stringent pre-authorization review processes before payment (with accompanying denials of coverage) has yielded small savings at the price of widespread dissatisfaction that is the very essence of why people distrust and dislike health insurance and managed care companies. This approach provided the grist for strong political invective in the health care debate as well as the political leverage to pass ACA legislation. In short, it is what made insurance companies and payers even more unpopular and provided the foil for insurance reforms which, while needed, are not nearly the whole answer as pointed out above.

A third approach – the shift of risk to individual providers and whole provider systems through capitated arrangements – was the rage in the 1990s with provider sponsored networks and appears to be coming into favor again by federal policy makers. It is useful to keep in mind that in the 90's, this approach resulted in well documented disasters and failures because the shift of risk was carried out in an inaccurate or unfair way that provider systems misunderstood and misjudged.

And, it turned out that providers, themselves, were not in a position to do what really needed to be done – to manage aggregate cost and demand and to coordinate the many steps needed to truly manage chronic care Members over a prolonged period of time. Many were hopelessly conflicted. How can hospitals afford to cut use levels? Should they fill their beds or try to reduce bed days? Should physicians be rewarded for cutting use of services, including testing and ancillary services or even admissions? Or, should they be rewarded for billing maximization?

The recent resurgence of interest in global capitation and in "bundled" payments for certain discrete services ("mini-capitations" or episode by episode capitations) is intended to foster better communication, stronger focus on outcomes and enhance accountability to achieve desired results. These approaches seek to include some provider "skin in the game" as a way of fostering these goals.

This is the essential idea behind the current interest at the federal level in Accountable Care Organizations (ACOs) which represent a renewal of the provider-sponsored network idea of the 1990s in a somewhat updated form. An ACO can include one or more hospitals, PCPs, specialty care providers and potentially other medical professionals and, as a system, would be paid a global, capitated amount for individual Members under its care. An ACO is based on a shared savings model within a global or partial capitation where some or all risk is shifted to the provider system.

Because ACOs are held accountable for aggregate cost and quality outcomes, they will presumably seek efficiencies and other ways to improve quality. Whether this approach will succeed this time is all in the details. What will be done differently? No one can yet say.

It will likely be the case, however, that ACO status may be achievable only by the same large, integrated health care systems referenced above whose unit rates and fees are invariably higher than the community average. Will these higher amounts be captured and preserved – in effect, be used as a base for capitated payments – in the bundled payments to come? Then, what will be achieved in making health care services more affordable?

It is certainly the case that, in the first four years of experience with the PCMH and TCCI Programs (Performance Years #1-4, 2011-2014), the systemically higher PMPM costs of Medical Care Panels that are part of large health care delivery systems was remarkably evident as discussed in the **Summary of Program Facts and Results** at the beginning of these Guidelines.

Wellness – Right Direction, But Weak Results So Far

Recently, there has been great interest among employers in offering wellness Programs to their employees in an attempt to encourage healthy lifestyles. A substantial "wellness" industry has evolved to support these initiatives. There is, as yet, no compelling evidence that these Programs work across a broad spectrum of the population – especially among those whose unhealthy lifestyles are most engrained and most conducive to multiple chronic disease.

If such Programs appeal only to those most inclined to a healthy diet, fitness and general well-being, then little impact will be seen relative to those who are in the top 10 percent of the Illness Burden Pyramid where so much use and spending is located – or, in those who are headed there.

Yet, there is no doubt that attention to wellness and risk mitigation must be elements in any successful drive to hold down cost growth. But, to become more impactful they must be based on stronger incentives of a financial nature to Members and providers alike. We believe they must also become the centerpiece of engagement between Members and PCPs and NPs rather than only between payers/employers and Members.

Conclusion – No One Idea Works – A New "Weave" Of Ideas Is Necessary

CareFirst operates in the midst of all the forces outlined above. It has been involved in all of the various approaches that have been tried so far and has had direct experience with all of their consequences. The company feels the pressures from all parties. In developing the PCMH and TCCI Programs, this collection of experiences has been carefully weighed as has the experience of others outside of our region.

As a not-for-profit payer, CareFirst operates essentially at cost with razor thin underwriting margins (0.5 percent of annual premium/revenue, on average, over the last decade). Any positive bottom line from operations is placed in company reserves for the protection of subscribers or for future rate moderation. Thus, over time, CareFirst premium increases directly reflect increases in health care costs and little else. On average, 83 to 85 percent of premium costs are for claims expenses.

In an attempt to control costs on behalf of its customers and subscribers, CareFirst relies on an extensive network of contracted providers which represents nearly 95 percent of all providers in the region. CareFirst offers an array of wellness Programs. Yet, premiums reflecting the actual care costs of Members continued to rise at alarming rates through 2011. It is clear that what has been done through the first decade of the 21st century (2000 – 2010) is not enough.

One only has to be in this position a short while to realize that the forces shaping the landscape are powerful, difficult to change, slow acting, and mighty in their impacts. Simply stated, health costs are rising as a result of tectonic forces that seem to be gathering strength. So called "solutions" cannot deal around the margin and expect to have an impact. There is a distinct need to change the incentives in the system that act on the Member and on the physician – starting with the PCP or NP – in such a way as to counteract these forces. This is an exceedingly complex and extensive undertaking.

There is also a distinct sense that CareFirst as a payer and we as a society are at a pivotal point: individuals and employers are concluding that they can afford neither the premiums they are charged nor the out-of-pocket costs they incur at the point of service. This undermines access to care and, in the long term, the quality of the services received.

Contracted provider networks – on which coverage plans depend – seem threatened by increasingly intense disputes over reimbursement levels and now, even legislative action. The individual consumer is coming to perceive that the value of his/her coverage is being eroded by the advent of high deductible plans and increasingly strident payer interventions, and is worried about less provider choice – all distinctly unattractive tracks to pursue – and all as costs continue to become more unsupportable. This is a toxic combination.

ACA rules governing health benefit plan designs – with their heavy cost-sharing and rigid rules – are making innovation more difficult. It is difficult to build incentives for risk mitigation and healthy lifestyles into these designs due to actuarial rules and other requirements. Ideally, one would want to provide incentives to Members to access care through more efficient and effective providers, to mitigate their health risks, to achieve better outcomes/results in dealing with these risks and to comply with Care Plans when they are sick. CareFirst has managed do so with some of its newer benefit plan designs, but is greatly constrained by ACA rules.

With all of this said, what can be done? Since no one thing has caused the problem, no one thing can "fix" it. Since the forces causing it are slow acting and powerful, the strategy to hold back cost growth or "bend the cost curve" cannot be expected to produce instant results. This makes a solution tough to conceive and even more challenging to implement.

This, then, is the context for the combined PCMH/TCCI Programs.

It is the specific intent of these Programs to steadily improve quality of care and outcomes over time. The improvement of quality outcomes will almost surely have a positive impact on cost results over time. Quality matters. Higher quality matters more. The highest quality matters most.

In the pages that follow, the key goals and design elements of these initiatives – and their intended interaction – are presented and explained.