A Time to Transform—A Potential to Partner

Mark B. Ganz

Cambia Health Solutions is focused on changing the health care equation. Formerly known as The Regence Group, Cambia looks holistically at the health needs of our communities and then invents, invests, and integrates solutions to support a more person-focused and economically sustainable future. Consistent with the health-reform-driven theme of coordinated care through effective partnerships, Cambia Health Solutions recognizes that, together, insurers, providers, and investors become the connective tissue that puts the individual first and delivers the right care at the right time in the right place, with quality health outcomes paramount in measuring performance.

Introduction

Like most Americans, I was glad to have my in box, mailbox, television, and phone take a break from politics after the November presidential election was over. But for me, as a health insurance leader, the outcome raised as many questions as it answered.

The President's re-election made it clear that we will see the implementation of the Affordable Care Act (ACA), the most sweeping restructuring of the American health care system since the passage of Medicare and Medicaid in 1965.

I view this as an unprecedented opportunity. But it's not yet clear what we will do with this moment of change. Will we heal our broken system, or simply add to its disorders?

Health insurance was born in the logging camps and timber mills of the Pacific Northwest. Money was scarce, and the jobs were dangerous. It was so risky, the community pooled together their hard-earned wages to prepay for medical services if one of their own became ill or injured. This was the beginning of modern health insurance, a noble concept of neighbor helping neighbor.

It is my deep commitment to the ideal of people coming together as a community, combining their resources to help individuals and their families in a time of need, that has motivated and engaged me in this industry for so long and gives me hope for the future. I continue to be hopeful, even as we face the many challenges before us today—not the least of which is the unsustainable cost of health care.

The Affordable Care Act is a misnomer. I think of it more as the Accessible Care Act. It opens access to medical care and health insurance coverage, but it doesn't address the costs that continue to pose significant challenges to affordability.

As a lifelong advocate for health care reform, I welcome the chance to bring more people into the health care system. I believe America holds the ability to provide quality health care for everyone. As the son of a physician, I have always believed that. It's the reason I entered this profession, and it's what keeps me going every day.

But if we simply bring more people into a system that's broken, it is likely to collapse under its own weight. To enact true health care reform, we need to do more than simply expand access to health insurance through government subsidies and programs. We should control the rising costs of health care that show no signs of slowing down.

We should improve the quality of that care to minimize errors and improve health outcomes. And, we should embrace innovation that increases the pace at which we can reach this transformative state.

Cost Is the Core Concern—A Roller Coaster That Must Change Course

As a nation we've been fortunate. We have benefitted from the latest in medicine and technology, and we have consumed these advances with fervor. Some have made us healthier. Others have simply treated our ills with mixed results.

Collectively, the cost has climbed, like a roller coaster leaving the station. We could feel each click of the chain pulling the car higher, but they were small bumps along the way. It wasn't until we reached the tipping point of affordability, the top of the hill before the 10-story drop, that we realized an insurance card is not an unlimited ride pass.

Each procedure has a cost, every doctor's visit comes with a bill that, as a community, we all pay together. While the ACA may provide subsidies, guaranteed coverage requirements and government programs that support access, the ACA doesn't erase the price of an MRI or an emergency room visit.

Medical costs are climbing, devouring our financial resources, forcing individuals to choose between a doctor's visit and a rent payment, and challenging our nation to debate between x-rays and infrastructure.

The following are a few projections:

- By 2016, health care will account for more than one third of the federal budget.
- By 2016, as a nation we'll spend $4.6 trillion on health care.
- By 2020, we'll spend 20 percent of our gross domestic product on health care.

The following are a few comparisons of health care costs with other public priorities:

- In 2011, 3 percent of the federal budget is allocated to education. The forecast is the same in 2020.
- As health care costs rise, support of welfare will decline from 13 percent to 9 percent of the federal budget, leaving millions of Americans to go it alone.
- By 2016, we'll spend nine times more on health care than on our country's crumbling roads and transportation system.

Our glide path is pretty clear. If we can't control our health care spending, we're going to have some very difficult decisions ahead, as individuals and as a nation. If we can't solve the cost conundrum, we'll feel the impact in our failing health, our emptying pocketbooks, and in our communities' ability to afford the key services that make our nation great.

We have the opportunity to make the roller coaster twist and turn and dip back toward the arc of affordability. But, the ACA alone will not return the car safely to the station. The subsidies available to some will not be available to others. Those who do qualify may still be left with an increasing bill well beyond their means. The ACA is a piece to the puzzle, but it's just the beginning.

We should look with a wider eye to all of the levers from which we can pull, and then decide together where the tracks can truly lead.

The First Step—Building the Bridge

Whether you support or oppose the ACA, it's difficult to argue against its success in awakening our nation and engaging our collective conversation. To date, we've been mired in the politics of it all. However, right beneath the surface lays the potential, and I believe the collective desire, to collaborate and innovate.

We can remain entrenched and divided to merely comply with a mandate and a piece of legislation. Or, we can embrace the opportunity to create a health care legacy founded on a recalibrated measure of quality and affordability. We have a shot to really make a difference in how health care is delivered in our country, and I believe we have the potential to succeed.

At Cambia Health Solutions, we first recognized the potential to truly transform health care about seven or eight years ago. Then known as The Regence Group, our focus for nearly 100 years had been health insurance.

Those Pacific Northwest loggers were our members, creating a network and a brand that was first in the nation to call itself BlueCross BlueShield. At our core, we've always been and will always be a health insurer.

However, the needs of our members have changed in the last 100 years as medical costs have outpaced individuals' ability to afford coverage and as technology has carved new avenues of innovative potential. Health insurance provides security, peace of mind, and protection during life's most difficult times. And, we would be naïve to think health insurance alone can address the many challenges now facing our modern health care system.

"Today, some patients can see upwards of five or six specialists with none talking to one another about the overall health and wellness of the individual. This is costly and ineffective."

I believe health insurance companies can become more responsive and innovative by addressing these challenges from a broader perspective. That's why, in 2011, The Regence Group became Cambia Health Solutions, and we adopted our cause: to serve as a catalyst to transform health care to become more person-focused and economically sustainable.

To do that, we are collaborating with providers to coordinate care and reduce costs. We are partnering with patients to improve health and increase engagement. We are aligning with entrepreneurs who share our values and vision for a more advanced and innovative tomorrow. We know we can't do this alone, and we come to this place in time just as the need for partnership has never been greater.

In the Idaho, Oregon, Utah, and Washington markets where our health insurance companies serve 2.2 million members, we've partnered with hundreds of providers to create new models of care delivery that will result in improved health and lower costs to our members. These partnerships have come in the form of both private and public efforts led by local coalitions and national initiatives.

In each endeavor and with every new relationship, we've seen a shared dedication to rolling up sleeves and driving results. Has it been easy and void of conflicts? No. Finding new approaches within a century-old health care system is challenging.

However, whether it's addressing health care disparities in the minority communities of Salt Lake City, coordinating the care of chronically ill Washingtonians, or developing new provider networks in and around the Portland metropolitan area, the partnerships that have developed have been sincere and committed to the best interests of our members.

As quickly as these regional partnerships have formed, so too have national relationships. Direct Health Solutions, a new venture within Cambia, is aggressively building and investing in new methods of health care transformation.

Largely tied to innovative technology, we've seen investors and entrepreneurs come to the table with awe-inspiring ideas that have the potential to dramatically affect the way care is accessed, delivered, and paid for.

Some of these relationships center on better ways of managing data to fix billing and clerical errors, while some tap into technology to identify new relationships between treatment and health outcomes. Others center on increasing access to providers at prices that consumers can afford.

It's these types of relationships, nonexistent just a year ago, that deliver a glimpse of our collective potential. I'm reminded of the famous Winston Churchill quote, "Americans can always be counted on to do the right thing . . . after they have exhausted all other possibilities."

We have reached the brink of health care affordability and, as a result, we're now doing the right thing. Together, we're building a bridge to new partnerships, connecting the health care of old with the health innovation of tomorrow.

The potential solutions are out there and within reach. The necessary path is clear, but no one person or group can walk the route alone. The scale is too large and the scope is too diverse to respond without support.

Five Fundamental Changes

While the poles are shifting in health care, the direction they're headed, or at least need to be headed, is largely agreed upon. If we can make five fundamental changes to the way care is delivered and paid for, we can make patients healthier and happier while reducing the costs associated with their care.

1. Patient-Centered Care

Patient-centered care at its core is about the right care at the right time at the right place. It really takes me back to my father's clinic years ago, when he listened to his patients and helped them problem-solve to prevent illness or lessen symptoms. One person treated another holistically and tracked whether the condition was improving or getting worse.

Somewhere along the line that changed. Patients began seeing different doctors for different ailments, and the medicine became more reactive than proactive. Today, some patients can see upwards of five or six specialists, with none talking to one another about the overall health and wellness of the individual. This scenario is costly and ineffective.

These patients have a multitude of chronic conditions that collectively make them very ill and very expensive to treat. In fact, this 5 percent of our population generates 50 percent of our nation's health care costs.

These patients are benefitting from coordinated care organizations that are developing across the United States, and specifically here in Oregon, as part of Gov. John Kitzhaber's transformation efforts.

These organizations unite doctors to treat and care for Medicaid patients. Their power lies in their ability to connect varying specialists through a holistic view of treatment. Their methods have been proven in a multitude of pilot programs and provide the potential to make patients healthier, at a fraction of the cost.

While coordinated care organizations have significant potential to improve care, they also need the support of technology to help providers communicate with one another, by sharing charts and notes that direct treatment across doctors and health systems.

Without a common platform to communicate, even the best intentions would languish in inefficiency and duplicative care. Our Direct Health Solutions team recognized this need and understood how critical a failure on this front would be.

In partnership with a company called Care Team Connect, we're able to offer CCOs a navigator tool designed to reduce readmissions and care gaps by improving information sharing between providers, community health workers, patients, and their family members.

Patient-centered care, however, means more than simply creating coordinated care organizations. Insurers like Regence are in a prime seat to connect the dots like never before.

Using new technology, we can analyze an individual's claims data to connect specialists, support treatment plans, monitor results, and improve health. We can do this on both micro and macro levels, partnering with local doctors and national entrepreneurs.

In Boston, there's a company called GNS Health Care with whom we partner. They're a big data analytics firm that owns supercomputers capable of crunching millions of numbers in a fraction of the time once thought possible.

Using the anonymous claims data of our 2.2 million members, GNS can uncover trends and patterns between diseases, treatments, and results. How did thousands of cancer patients respond to a certain drug? How did a widely used course of treatment improve the symptoms of diabetes?

Together, insurers, providers, and investors become the connective tissue that puts the individual first and delivers the right care at the right time in the right place with quality health outcomes paramount in measuring performance.

2. Reward Quality, Not Quantity

For a moment, let's think of a doctor's visit like a trip to your local car mechanic. If you took your car in with a bad alternator and it wasn't fixed when you got it back, would you still pay for the mechanic's services? Right now, we pay doctors and hospitals every time they look at a patient, as opposed to paying when that patient feels better.

This is what we mean when we talk about a payment system that drives volume of services rather than improved outcomes, or fee-for-service. It's costly and wasteful, and compared to other developed countries, our health is no better and sometimes worse.

Not only are we paying for care that doesn't make us healthier, but we're paying more for that care than other nations who are recognized for delivering better outcomes. This has to change and thanks to the partnership of committed doctors and hospital systems, it's starting.

Providers and payers across the country are beginning to partner in new and collaborative ways to shift the model from payment for services to payment for quality health outcomes.

Remember those 5 percent of patients who consume 50 percent of health care costs? Doctors are agreeing to compensation plans tied to the direct improvement in the health of that percent of patients. Does that cut into their income?

In some cases, it does. But these providers have agreed to become part of the solution, and as a result we can expect to see healthier patients at lower costs.

3. Healthier Americans, Fewer Mistakes

Part of the quality equation comes in the form of medical waste and mistakes. As a country, the Institute of Medicine has found that we spend $750 billion a year on inefficient, redundant, fraudulent, or excessive medical care. In September, the *Wall Street Journal* reported a headline that surged across the nation: "Medical errors kill enough people to fill four jumbo jets a week."

We deserve a health care system that makes us healthier, not sicker. The solutions are available and proven. Johns Hopkins has adopted the use of medical care checklists, a practice that has shown the ability to reduce infections, save lives, and save millions of dollars in wasteful care. Yet, this is far from standard practice in every hospital.

The Johns Hopkins model is an example of an opportunity for providers to share with one another

the quality-focused safety measures and best practices that could lead to better care across our country. This work is beginning with the leadership of the Department of Health and Human Services and the National Strategy for Quality Improvement in Health Care.

With a variety of health care stakeholders at the table, this initiative identified three aims: better care, healthy people/healthy communities, and affordable care. The work is in its infancy, but it serves as an example of our ability to capture our collective best and share it for the greater good of medicine.

In its first year, this effort was able to (1) foster greater collaboration between state and federal governments, (2) review and refine national quality measures, and (3) bring to the table community partners that can effect a grassroots focus on prevention and healthy living. There remains a good deal of work ahead, but through discovery and dialogue, we can effect positive change.

4. A World of Wellness

Never has it been more apparent that an ounce of prevention is worth a pound of cure. We invest heavily in treatments and their delivery, yet we invest only a fraction of that in prevention. Prevention is less exciting and less profitable, but it is where we can make significant progress. I've seen this with our employees at Cambia Health Solutions.

From 2005 to 2009, by engaging our employees in a workplace wellness program, we were able to save $9.2 million in medical claims, disability claims, and unplanned absences. Our employees are feeling better and spending less on medical bills.

We paired this concept with healthier food options in our cafeteria, and employees now select healthy options 75 percent of the time. It's a one-two punch that's making a difference.

ACA pilot programs will subsidize businesses for bringing robust wellness programs, such as these, to worksites across the country. But again, partnership here will be key. We've been fortunate to work with a number of our customers, well-known Oregon companies, who are committed to improving the health of their employees.

Beyond simple biometric screenings and rewards for healthy eating, these companies are installing health care clinics on their campuses. They're making engagement easier for their employees and as a result, their employees are taking a more active role in their health care.

These are our members. And, when they are healthier, they spend less in medical claims which lead to a lower cost of their premiums.

It's easy for wellness to simply become a tag line to a campaign or an annual company award, but preserving health is much more affordable than restoring health, and it can dramatically affect the overall cost of care that plagues our nation's health care system.

5. How Much Does This Really Cost?

I used the analogy of an auto-repair shop. Now imagine your alternator's fixed and your car's running. You drive to a local grocery store and inside you discover none of the products have prices or expiration dates.

It's nearly impossible to tell how much you are about to pay for something or if it's any good. When you get your receipt you can't make heads or tails of how much you were just charged. You may have made some different choices if you could have seen the impact on your bill, but instead you're left to wonder how much you paid for each item and you have a feeling you'll need to come back for more.

This is our health care industry, one lacking transparent prices and quality measures. How can we expect patients to carry their weight in solving the challenge of cost if they can't see the prices on the store shelves?

Engaging consumers begins with unmasking those costs and giving them quality measures to choose from. Consumers are demanding access to this information just as they are with other parts of their lives. Take travel, for example. Ask someone what application they use to plan a trip and they may name Yelp, Travelocity, or Kayak. Ask them what application they use to plan a trip to the doctor and they may look at you with a very confused stare.

Seven years ago, we created online tools our members could use to begin evaluating cost and quality of their medical care. This year, these tools were optimized for smart phones and were honored by the BlueCross BlueShield Association. We're now selling our solutions, under the name HealthSparq, to other health insurance companies.

These tools are popular with our members, who have told us that they are changing the way they shop as a result. They're saving money and choosing to visit providers based on reviews provided by other members. It's making the health care experience more cost-efficient and enjoyable for our members.

So, Is Oregon Succeeding in the Five Fundamentals?

While it was tempting to wait and see if the ACA survived legal and political challenges, Oregon

chose early on to embrace health care transformation and take action to prepare for 2014. Positive partnerships are emerging on a regular basis, care coordination is improving, exchange development is progressing, and access to care is increasing.

However, the challenge of rising costs continues to remain a burden on small businesses and individuals. With any great challenge must come great partnership.

Comprehensive Primary Care Initiative (CPCI)

Oregon's collaborative spirit is once again surfacing as primary care practices, providers, and payers are coming together to better coordinate care and test new ways to pay for that care. CPCI unites 68 primary care practices throughout the state in the pursuit of improved quality, increased patient satisfaction, and reduced costs.

Oregon is one of four states to participate in the CPCI under the leadership of the Centers for Medicare and Medicaid Services (CMS). CMS estimates that, as a result, over 300,000 Medicare beneficiaries will be served by more than 2,000 providers nationwide.

Cambia Health Solutions is deeply involved in the CPCI project because we see the potential this initiative provides for both improving care and reducing cost. Regence BlueCross BlueShield of Oregon is the largest statewide payer participating in the CPCI program.

Our Direct Home Solutions partner, RiseHealth, is exploring opportunities to utilize new technology that will share cost and utilization data among payers and providers. This holistic approach aligns with our mission of transforming health care into a more person-focused and sustainable model, and we're pleased to have the opportunity to be involved in such important work.

Accountable Care Organizations (ACOs)

ACOs, also known as Coordinated Care Organizations (CCOs), under Governor Kitzhaber's transformation vision, are limited partnerships among individuals, providers, health plans, and other key stakeholders with delegated accountability for cost, quality, and individual experience. Much like the CPCI, ACOs strive to better coordinate care, improve patient health, and reduce costs.

While the Governor's focus is on coordinating the care of Medicaid patients in Oregon, the concept of care coordination can be applied to any patient group. With its proven ability to improve care and reduce costs, Regence BlueCross BlueShield of Oregon will launch RegenceACO in January of 2013.

Available to fully insured, large group employers, RegenceACO will deliver a more collaborative experience with providers, better coordination of care, lower long-term claims costs, and higher employee satisfaction.

Exchange Development

Oregon is making significant headway in developing its health insurance exchange. Called Cover Oregon, the exchange will allow individuals and small business employees to shop for insurance coverage across carriers while grouping similar coverage options together in metal categories of platinum, gold, silver, and bronze.

The exchange poses a great opportunity to expand access to health insurance coverage for Oregonians; however, it does not reduce health care costs. Additionally, while Oregon remains ahead of many other states in planning for the exchange, a great deal of work is still required to ensure the exchange is fully operational by 2014.

Cost Challenge Remains

The cost of care, nationally and here in Oregon, remains the single largest challenge that we must address. While many Oregonians already have been pushed to, or past, the brink of health care affordability, analysts forecast a surge of cost entering the Oregon market in 2014.

As individuals with pre-existing conditions secure health insurance coverage and care, some for the first time in years, and as mandated coverage requirements become active, analysts at the Wakely Consulting Group expect individual insurance premiums to spike by as much as 55 percent. This will come as an unwelcome surprise to many.

Additionally, new federal taxes and fees will take effect on January 1, 2014, to fund the many coverage expansions and other provisions under the ACA. A premium tax that applies to individual and fully insured group coverage, Medicaid-managed care, and Medicare Advantage plans is expected to total $8 billion at the outset, nationally. This will increase to $14.3 billion in 2018.

An analysis by Oliver Wyman Actuarial Consultants estimates that this tax will increase premiums in the insured market on average by 1.9 percent to 2.3 percent in 2014, and by 2023 will increase premiums by 2.8 percent to 3.7 percent.

Not only will these increased fees reach consumers, but a change in the premium cost between the highest and lowest rates associated with age will change. Older patients typically need more care and more expensive care than younger patients. To ensure that younger patients aren't forced to absorb the cost of this care, age bands are put into place.

In Oregon today, older consumers can pay as much as five times that of younger consumers for health care. Starting in 2014, that ratio will be reduced to three to one, meaning younger consumers will be required to pay more for the same care. It's a cost many can't afford, and some simply will refuse to pay by foregoing insurance all together and paying the penalty.

These are all costs that the majority of Oregonians and their employers are unaware of. While the media has largely covered the politics surrounding the ACA, they have rarely dissected the fine print and its associated costs. As a result, 60 percent of Americans acknowledge they don't know how the ACA will directly impact them.

Similar to the need to partner in the pursuit of health care transformation, the need for collaboration is also vital in the education of Oregonians. I encourage anyone with a stake in our state's health care system to ask questions, seek information, and turn to a trusted source for guidance. My fear is that as these broad changes and significant cost increases arrive, too many will attempt to wade the waters alone.

The potential to overlook opportunities to access support and coverage, or incur unnecessary penalties for failed action, is very real without a trusted resource by one's side.

Conclusion—We Have to Do It, Period

Can we do it? Can we put aside the partisanship and rancor that has engulfed our recent health care conversation, and agree to partner and collaborate in support of a cause bigger than ourselves? We have both a genuine need and an opportunity before us. To resolve the first and capitalize on the second, we should be fearless to failure and confident of our collective ability to solve problems.

Despite all that health care does to improve the lives of so many Americans, we have to be better. Too many people are left unable to afford coverage. Too many will look to Medicaid for refuge as the cost of their care continues to rise.

As this occurs, our nation will grapple with the need to pay for that care at the expense of other critical services. Costs will shift to private insurers, forcing consumers to rely on subsidies that don't deliver the necessary level of assistance.

When I think about the current state of our nation's health care, it brings me back to the initial conversations we had within my company nearly a decade ago. At the time, we couldn't connect all the dots, but we realized that the challenges ahead would be many and diverse.

We had to be humble to the fact that we didn't have all the answers. Fast forward to today, and the need to engage these challenges from multiple angles and with varied expertise could not be clearer.

To succeed as a business and as a leader in health care, we have chosen to look at the problem differently. Is this the only way to transform our nation's troubled system? No. For every challenge, there exists a wealth of solutions. This is our collective path, however, and with 6,000 employees and a growing network of new and collaborative relationships working together, we're determined to make it better.

Just as the loggers joined forces in the forests of the Pacific Northwest a century ago, we unite with all the benefits of a modern world at our side today. We can move quickly, bring about change, and drive results if we continue to ask ourselves several questions along the way. Are we improving access to health care? Are we improving the quality of that care? Are we making that care more affordable?

Hospitals, doctors, and pharmaceutical companies can't fix all the problems. Neither can regulators, legislators, or health insurance companies. It's going to take a collective approach—a triangle of responsibility with each side holding up its shared weight.

Can we do it? I believe the answer is yes. We have to do it, for ourselves and for those who will face life's toughest challenges in the years ahead.

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