SOA 2012 Annual Meeting & Exhibit
October 14-17, 2012

Session 49 PD, Trend—Future Drivers and Bending the Cost

Moderator:
John Patrick Kinney III, FSA, MAAA

Presenters:
Matthew Peter Day, FSA, MAAA
Carol Simon, Ph.D.
Dale H. Yamamoto, FSA, EA, FCA, MAAA

Primary Competency
Strategic Insight & Integration
Trend—Future Drivers and Bending the Cost Curve

Society of Actuaries 2012 Annual Meeting
Session 49
October 15, 2012

About The Health Care Cost Institute (HCCI)

• HCCI is a non-profit, independent, non-partisan research institute
  – Provide most comprehensive source of information on health care activity
  – Promote research on the drivers of escalating health care costs and utilization

• Health Section breakfast (Session 124)
  – Wednesday, October 17th
  – 7:15 – 8:15 am
Background

• First report released on May 21, 2012
  – Primarily compared 2010 to 2009
• Second report released September 25, 2012
  – Primarily compared 2011 to 2010
  – More data
  – Additional data comparisons
• Key statistics by
  – Service category
  – Geography
  – Age

Cost Change by Service

- Inpatient
- Outpatient
- Professional
- Drugs
Cost Change by Geography

Trend rates shown are average annual from 2009 to 2011.

Cost Change by Age

Trend rates shown are average annual from 2009 to 2011.
### 2009-11 Trend Components

<table>
<thead>
<tr>
<th></th>
<th>Per Capita</th>
<th>Cost Trend</th>
<th>Price Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Utilization</td>
<td>Price Paid</td>
<td>Unit Price</td>
</tr>
<tr>
<td>Inpatient</td>
<td>4.2%</td>
<td>-2.1%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>7.2%</td>
<td>-0.3%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Outpatient other</td>
<td>7.8%</td>
<td>2.7%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Professional</td>
<td>3.0%</td>
<td>0.6%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Prescriptions – Day’s Supply</td>
<td>1.7%</td>
<td>−0.1%</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

**General CPI-W**

2.8%

Note: Drug price trend shows unit price change with 2009 utilization and intensity is mix between brand and generic utilization (i.e., mix).

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### Inpatient per Capita

- **Overall**: $963 (4.2%/yr)
- **Surgical**: $887 (3.7%/yr)
- **SNF**: $600 (5.0%/yr)
- **MHSA**: $800 (17.7%/yr)
- **Medical**: $400 (2.7%/yr)
- **Maternity**: $200 (7.1%/yr)
2009-11 Trend Components

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<th>Price Trend</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Utilization</td>
<td>Price Paid</td>
</tr>
<tr>
<td>IP-MHSA</td>
<td>17.7%</td>
<td>8.6%</td>
<td>8.3%</td>
</tr>
<tr>
<td>IP-Maternity</td>
<td>7.1%</td>
<td>1.0%</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

Outpatient per Capita

- Overall (7.4%/yr)
- Other (17.3%/yr)
- Radiology (3.1%/yr)
- Lab/Path (4.6%/yr)
- Ancillary (5.6%/yr)
- OP Surgery (7.1%/yr)
- Observation (6.3%/yr)
- ER (7.5%/yr)
### 2009-11 Trend Components

<table>
<thead>
<tr>
<th></th>
<th>Per Capita</th>
<th>Cost Trend</th>
<th>Price Trend</th>
<th>Utilization</th>
<th>Price Paid</th>
<th>Unit Price</th>
<th>Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>7.5%</td>
<td>-0.6%</td>
<td>8.1%</td>
<td>8.1%</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other services</td>
<td>17.3%</td>
<td>7.7%</td>
<td>8.9%</td>
<td>3.9%</td>
<td>4.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Professional per Capita

- **Overall (3.0%/yr)**
- **Surgery (2.6%/yr)**
- **Radiology (-4.0%/yr)**
- **Prev-SCP (3.6%/yr)**
- **Prev-PCP (7.6%/yr)**
- **Lab/Path (5.3%/yr)**
- **Other (1.7%/yr)**
- **OV-SCP (8.8%/yr)**
- **OV-PCP (1.3%/yr)**
- **Anesthesia (5.1%/yr)**
- **Admin Drugs (8.2%/yr)**

![Chart showing professional per capita costs for different categories]
2009-11 Trend Components

<table>
<thead>
<tr>
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<th>Cost Trend</th>
<th>Price Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Utilization</td>
<td>Price Paid</td>
</tr>
<tr>
<td>Lab/Path</td>
<td>5.3%</td>
<td>2.4%</td>
<td>2.7%</td>
</tr>
<tr>
<td>OV-SCP</td>
<td>8.8%</td>
<td>3.7%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Admin Drugs</td>
<td>8.2%</td>
<td>0.8%</td>
<td>7.3%</td>
</tr>
</tbody>
</table>

Prescription Drugs per Capita

- Overall (1.7%/yr)
- Other (19.9%/yr)
- Generic (-4.7%/yr)
- Brand (4.7%/yr)
### 2009-11 Trend Components

<table>
<thead>
<tr>
<th>Per Capita</th>
<th>Per Capita</th>
<th>Number of Scripts/1000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2011</td>
</tr>
<tr>
<td>Brand</td>
<td>4.7%</td>
<td>$478</td>
</tr>
<tr>
<td>Generic</td>
<td>-4.7%</td>
<td>$262</td>
</tr>
<tr>
<td>Total *</td>
<td>1.7%</td>
<td>$748</td>
</tr>
</tbody>
</table>

**Percent of Total**

<table>
<thead>
<tr>
<th></th>
<th>Brand</th>
<th>Generic</th>
<th>Total *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>64%</td>
<td>35%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>68%</td>
<td>31%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>25%</td>
<td>74%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>21%</td>
<td>78%</td>
<td>100%</td>
</tr>
</tbody>
</table>

* Note: Numbers do not add up as a small percentage of drugs were uncategorizable.

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### 2009-11 Trend Components

<table>
<thead>
<tr>
<th>Script Cost Change</th>
<th>Cost per Script</th>
<th>Number of Scripts/1000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2011</td>
</tr>
<tr>
<td>Brand</td>
<td>15.4%</td>
<td>$202</td>
</tr>
<tr>
<td>Generic</td>
<td>-6.7%</td>
<td>$38</td>
</tr>
<tr>
<td>Total *</td>
<td>2.2%</td>
<td>$80</td>
</tr>
</tbody>
</table>

**Total w/ 2009 weights**

| 7.9%  | $80  | $93  |

Note: Numbers do not add up as a small percentage of drugs were uncategorizable.

The total with 2009 weights is based on number of prescriptions. The adjusted cost trend shown on page 7 is based on days supply. Therefore, the above price includes a change in number of days supply per prescription.
Can we slow the drivers of health care costs?
Carol J. Simon, SVP and Director Optum Institute

Reform creates new challenges to cost control

2014 Growth Rates by Selected Sector, Before and After the Impact of the Affordable Care Act.

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group

Sustainable?

In the next 2-3 years the health care system will be

- Better: 26%
- Same: 33%
- Worse: 33%
- Not sure: 8%

<table>
<thead>
<tr>
<th></th>
<th>Physicians (A)</th>
<th>Consumers (B)</th>
<th>Hospital Executives (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26%</td>
<td>25%</td>
<td>48%</td>
</tr>
<tr>
<td></td>
<td>33%</td>
<td>39%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>33%</td>
<td>23%</td>
<td>31%</td>
</tr>
<tr>
<td></td>
<td>8%</td>
<td>13%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Today’s Talk: Redirecting Cost Drivers

**How much of cost growth can be controlled?**
- Economic research on cost drivers
- Controllable vs. non-controllable

**Focus on controllable stuff: SR vs. LR**
- Poor Health Behaviors
- Evidence-based practice
- Competition and Incentive alignment
- Waste and Fraud

**Actions & Evidence**
- Value based payment
- Delivery system redesign
- Health Information Technology
Half of health care cost growth is potentially controllable, due to avoidable utilization and higher prices

Uncontrollable factors
- Population growth, 12%
- Aging, 5%
- General inflation, 30%

Controllable factors
- Excess medical inflation, 34%
- Growth in utilization and intensity, 19%

*Excess medical inflation is defined as increases in prices for health care services above the general inflation rate. Not all growth in utilization and intensity is excess although these costs may be controllable. The estimated split by excess medical inflation and utilization/intensity is based upon 2001-2008 data published by the Office of the Actuary, CMS.

Optum examined distinct factors that drive our major cost-categories, reviewing 22 factors that contribute to controllable and uncontrollable costs

Uncontrollable Factors
- Population demographics
- Aging/end of life

Controllable Care Management Factors
- Lifestyle factors
  - Tobacco use
  - Obesity
  - Excess alcohol consumption
- Care management processes
  - Preventable medical errors
  - Low use of evidence-based medicine
  - Inadequate disease management
  - Low use of medical homes
  - Lack of comparative effectiveness research (CER)
- Low use of health information technology (HIT) (portion of)

Controllable Market Competition Factors
- Pharmaceutical expenditures
  - Direct-to-consumer ads
  - Suboptimal use of generics
  - Lack of price negotiation
- Hospital and insurer competition
- Cost shifting
- State mandates
- Malpractice

Controllable Transaction Factors
- Fraud, abuse, & billing mistakes
- Administrative/paperwork-related costs
- Low use of HIT (portion of)

Controllable Incentive Factors
- Excess consumption due to low cost sharing
- Higher prices due to over consumption
- Tax-subsidies for insurance
- Provider incentives under FFS

Controllable Other Factors
- Technological changes/innovations
- Nursing shortage
- Provider salaries
- Uninsurance
Current spending could be significantly reduced: align incentives, manage disease, promote competition and improve transactions

Addressing the controllable factors that affect the burden of disease can yield potential savings of ~$560 billion annually

*Low/non use of comparative effectiveness research (CER) $21 billion
Preventable medical errors $48 billion
Deficiencies in care coordination & disease management $27 billion
Low use of health information technology (HIT) $24 billion
* Savings from use of CER are tied to use of economic incentives to comply with clinical guidelines

Source: Lewin Group estimates
Addressing *controllable* factors that affect market competition yields savings of ~$160 billion annually

Source: Lewin Group estimates

Increasing concerns: Health care competition vs. consolidation

**Current Trends** point to accelerating market consolidation:
- Uptick in physician group mergers, Physician-hospital alignment & acquisition
- Integration required for new delivery models, ACOs

Lack of competition is estimated to add 5% to hospital prices nationally, or $38 billion, annually
- Impact is higher in the least competitive markets, raising hospital prices 30% or more above competitive norms

Addressing incentives that result in higher utilization and prices can save ~$164 billion (6% of projected 2010 NHE)

*Incentives can include agency costs, moral hazard, and tax preferences

- Higher prices due to perverse incentives: $48 billion
- Excess utilization due to poor incentives: $116 billion

- Provider-related excess costs (agency costs) exist in fee-for-service systems such that certain incentives prompt health care providers to provide excess services.
- Consumer-related costs (moral hazard) also may exist as health insurance insulates patients and providers from the true cost of services which can lead to some excess use.
- Tax incentives may encourage employers to purchase more coverage, contributing to higher use and prices.

Improving transactions can yield potential savings of $220 billion (8.5% of projected 2010 NHE)

- Fraud and abuse: $169 billion
- Administrative/paperwork costs*: $51 billion

*Administrative costs refers to billing and insurance-related costs (BIR), including the cost of billing errors
Source: Lewin Group Estimates
How to get there?
-- Value based payment reforms
-- Delivery system redesign
-- Transparency-competition
-- Evidence-based practice & HIT

Two complementary approaches to promoting value

Improve performance distribution:
Shift patient flows to high performers

Require measurement, incentives and transparency
Improving performance by promoting Centers of Excellence

139 Adult Heart Transplant Centers Volume & Survival Rate

![Graph showing survival percentages and number of heart transplants for non-network and in-network centers.]

**Promoting Quality & Cost Transparency**

**UnitedHealth Premium® Designation**

**Quality First plus Cost Transparency**
- Designates physicians on quality and efficiency
- Longest running designation program (since 2005)
- National industry, evidence-based and medical specialty society standards are used to evaluate individual physicians on more than 75 conditions and 300 measures
- Quality first: Only physicians who meet the quality designation criteria are eligible for cost efficiency designation

**Access**
- 145 markets and 21 specialties account for more than 50% of all medical costs; includes Primary Care Physicians and Specialists

**Broad Application**
- Available to all members at no additional cost – designations integrated into all customer service, clinical, and online experiences
- Benefit designs based on UnitedHealth Premium® designation
Variation in Quality and Efficiency Episodes Are Measurable

![Graph showing variation in quality and efficiency episodes.]

Consumer Designation Display on myuhc.com

- ★★★ UnitedHealth Premium® Quality and Cost Efficiency criteria met
- ★★★ UnitedHealth Premium® Quality criteria met
- Not Enough Data to Assess
- Not Displayed Upon Physician Request
- Not Evaluated

Physicians receive benchmarking report
Average savings from using doctors designated for Quality and Efficiency in UnitedHealthcare's Premium Designation Program

Translates to 1-3% cost savings for employers

Source: UnitedHealthcare Premium Designation Program.

Payment reform strategies involve varying level of risk and integration

Compensation Continuum
(Level of Financial Risk)

Small % of financial risk
- Fee-for-service
- Performance-based Contracting
- Bundled and Episodic Payments
- Limited Integration

Moderate % of financial risk
- Physician + Hospital
- Shared Savings
- Moderate Integration

Large % of financial risk
- Patient-centered Medical Home
- Shared Risk
- Full Integration

- Capitation + Performance-based Contracting

UnitedHealth is working to deploy a variety of options with its network providers based on their readiness to accommodate varying levels of risk
Move to more value based payment models?

While many physicians believe FFS encourages the use of more services or more expensive services, few are eager to adopt incentive-based pay.

Fee-for-service payment encourages the use of more services or more expensive services

- **Agree**: 37%
- **Neutral**: 32%
- **Disagree**: 27%
- **Not Sure**: 4%

Source: UnitedHealth Center for Health Reform & Modernization / Optum Institute / Harris Interactive survey of physicians, hospital executives, and consumers, June 2012.

Physicians are concerned about the risk associated with capitated payments

Capitated payments shift too much risk to providers

- **Agree**: 60%
- **Neutral**: 25%
- **Disagree**: 7%
- **Not Sure**: 8%

Source: UnitedHealth Center for Health Reform & Modernization / Optum Institute / Harris Interactive survey of physicians, hospital executives, and consumers, June 2012.
Physicians are familiar with “bundled” or “episode-based” payments but many are reticent to participate in them.

**How familiar are you with proposals to create “bundled” or “episode-based” payments?**

- At least somewhat familiar: 76%
- Not at all familiar: 24%

**How interested would you be in participating in a “bundled” or “episode-based” program?**

- Extremely or very interested: 4%
- Interested: 9%
- Somewhat interested: 31%
- Not at all interested: 33%
- Not sure: 16%

Source: UnitedHealth Center for Health Reform & Modernization / Harris Interactive survey of physicians, hospital executives, and consumers, November 2011.

Evidence on savings from delivery system redesign pilots is mixed

- **CMS Physician Group Practice Demo**
  - Uneven savings across participants; from savings of ~$800 to increased spending in some groups
  - Evidence of savings among chronic, high cost patients ~$500, annually (JAMA 2012)
  - Modest improvements in quality

- **ACOs – too new to evaluate**
  - Efficiency vs. market power concerns as physician-hospital consolidation increases

- **Primary Care Medical Homes**
  - Mixed results: savings of 2—8% costs, depends on population
  - All models require practice transformation and investment to manage clinical and financial risks
The Future Holds More Risk: Shift from Volume to Value

Acceptance of Performance-Based Risk in the Next 10 Years

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Physicians</th>
<th>Hospital Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 50% of overall reimbursed services</td>
<td>7%</td>
<td>18%</td>
</tr>
<tr>
<td>26-50% of overall reimbursed services</td>
<td>15%</td>
<td>22%</td>
</tr>
<tr>
<td>10-25% of overall reimbursed services</td>
<td>35%</td>
<td>42%</td>
</tr>
<tr>
<td>Less than 10% of overall reimbursed services</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Not sure</td>
<td>27%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Note: This question was not asked among Consumers

Base: All Qualified Respondents: (Physicians n = 1,000, Hospitals n = 400)

Q1010/5010: How much risk do you think practices/hospitals in your community will accept performance-based risk on...?

The Incentive Alignment Opportunity

The Challenge of Managing Financial Risk

Preparation for Greater Responsibility for Managing Patient Care

<table>
<thead>
<tr>
<th>Preparation for Greater Responsibility for Managing Patient Care</th>
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<tbody>
<tr>
<td>Physicians (A)</td>
</tr>
<tr>
<td>Extremely prepared</td>
</tr>
<tr>
<td>3%</td>
</tr>
<tr>
<td>3%</td>
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</table>

Preparation for Greater Financial Risk for Managing Patient Care

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<tr>
<td>Extremely prepared</td>
</tr>
<tr>
<td>3%</td>
</tr>
<tr>
<td>3%</td>
</tr>
</tbody>
</table>

Note: This question was not asked among Consumers

Base: All Qualified Respondents: (Physicians n = 1,000, Hospitals n = 400)

Q1025/5035: How prepared are physician practices/hospitals in your community to assume...?
"The significant problems we face cannot be solved at the same level of thinking we were at when we created them."

- Albert Einstein (1879-1955)

Thank You

Contact:
Carol J. Simon, PhD | Director, Optum Institute
952-936-1602 | carol.j.simon@uhg.com
Advancing the Twin Goals of Improving Health Care Quality While Slowing Spending Growth: BCBSMA’s Alternative Quality Contract (AQC)

Matthew Day, FSA, MAAA
Vice President & Senior Actuary
Blue Cross Blue Shield of Massachusetts

AQC Overview
BCBSMA’s Highest Priority is to Make Quality Health Care Affordable

The most promising way to slow rising health care costs is to enable the delivery system to improve the quality, safety, and effectiveness of care. To address both cost and quality, we need a health care system that aligns financial and clinical goals.

That’s why BCBSMA developed the Alternative Quality Contract (AQC).

Highlights of the AQC Model

| Sustained partnerships | • Encourage investment in long-term quality initiatives  
|                        | • Promote the integration and coordination of care  
| Global payment budgets | • Support collaboration between primary care and specialist providers and community and tertiary hospitals  
|                        | • Reward efficient providers with increased margins  
|                        | • Create opportunities for the implementation of alternate care delivery models (e-mail, group visits, etc.) and other innovations  
| Performance incentives | • Robust, nationally accepted performance measure set creates accountability for quality, safety and outcomes across continuum  
|                        | • Tie payments to achieving the goals of safe, effective, patient-centered care.  
| Network Support        | • Provide comprehensive support to providers in the AQC contract by providing actionable data, financial reports, training, and collaborative opportunities, as well as communication and consultative support.  
  
Massachusetts Blue Cross Blue Shield of Massachusetts
Financial Model Overview

1. Global Budget
   - Based on historical claims
   - Includes members’ total medical expenses

2. Trended and Adjusted Annually
   - Trended at the network/region trend less a defined percentage
   - Adjusted for relative change in health status and Rx benefit coverage

3. Surplus Opportunity
   - Annual, retrospective settlement of actual expenses to budget
   - Share of surplus/deficit dependent on quality score results
     - Higher quality = greater share of surplus / lower share of deficit

4. Quality Performance Incentive
   - PMPM amount dependent on performance on broad set of quality measures

Global Budget

The AQC starts with a global budget based on the claims history of the members to be covered.

This “starts you where you are,” aiming to generate savings over time - no immediate shock to the system.

AQC groups are large (35,000 average group, 7,000 minimum), so one year of claims is a stable base data set
- Analysis shows health status adjusted Total Med. Expense (TME) has low volatility at these sizes

- The budget includes all claims for the covered members, including those not provided by the AQC group
### Trend Targets

AQC groups must perform better than average to earn a surplus on the efficiency program.

- The global budget is trended at the network/regional trend, less a defined percentage.
  - This high bar is balanced with the robust quality incentives available to the group:
    - The focus is on quality + affordability.
  - The network trend serves as an adjustment for macro changes to trend:
    - Economic conditions, pandemics, etc.
  - The deduction is a negotiated factor, which can account for the groups’ starting relative cost and readiness for global management.

### Budget Adjustments

The budget trend is adjusted for factors outside the groups’ control.

- The goal is to retain insurance risk with the Plan; holding providers accountable only for what they can control.
  - Health Status
    - Adjust for the groups’ change in health status relative to the benchmark change.
    - Initial health status level is embedded in the budget, but we adjust for changes.
    - More accurate concurrent models can be used due to the retrospective settlement.
  - Benefit coverage
    - Adjust for the relative change in the proportion of the members with carved out Rx.
  - Changes in the provider group
    - Adjust if a large number of doctors are added or leave the group.
  - High Cost Claims
    - Budget deduction taken and claims over an attachment point are reduced.
What AQC Results are we Seeing?

Significant Growth in the AQC, 2009-2012
(Current as of August 2012)

- In-State HMO members of an AQC PCP, membership may fluctuate

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
<th>Memberships</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>26%</td>
<td>328,000</td>
</tr>
<tr>
<td>2010</td>
<td>32%</td>
<td>359,000</td>
</tr>
<tr>
<td>2011</td>
<td>43%</td>
<td>428,600</td>
</tr>
<tr>
<td>2012</td>
<td>77%</td>
<td>649,425</td>
</tr>
</tbody>
</table>
AQC is Significantly Improving Quality

Year-one improvements in quality were greater than any one-year change seen previously in our provider network

- Every AQC organization showed significant improvement on the clinical quality measures.
  - Exceptionally high performance seen for all clinical outcome measures.
  - There were no significant changes in AQC groups’ performance on patient care experience measures overall.

Year two showed continued significant quality improvements among AQC groups relative to others

- Some groups are nearing performance levels believed to be “best achievable” for a population.
- Significant improvements occurred in patient care experiences, including improved doctor-patient communication, access to care and integration of coordination.

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Year-One Results: Formal Academic Evaluation

The NEW ENGLAND JOURNAL of MEDICINE

Health Care Spending and Quality in Year 1 of the Alternative Quality Contract

“...The AQC system was associated with modestly lower medical spending in the first year after implementation... a 1.9% savings relative to the control group (non-AQC).”
Year-Two Results: Formal Academic Evaluation

"Participation in the contract over two years led to savings of 2.8% (1.9% in year 1 and 3.3% in year 2) compared to spending in nonparticipating groups... savings were substantially larger in the no-prior-risk subgroup (8.2%)."

AQC is Significantly Reducing Costs

• BCBSMA is on track to reach our goal of reducing in half the rate of increase in health care costs over the five years of the original contracts.

In year two, savings were generated in three key areas:

1. Reduced inpatient admissions: The AQC trend for hospital admissions was more than 2% lower than for non-AQC providers—which equates to over 300 avoided admissions and a savings of around $6 million in costs.

2. Improved use of high tech radiology: AQC providers better managed the use of high-tech radiology, representing a savings of 1,500 unnecessary scans and $2 million in avoided costs.

3. Using less costly settings for care: AQC groups continue to refer to high-quality, lower-cost facilities for basic tests and procedure. These changes resulted in $2.5 million in savings in 2009 and 2010.
## Provider Experience

"The way the AQC program allows the care team to deliver better care is it allows the primary care physician and other physicians to spend more time with the member. The amount of care that we’ve been able to give the chronic disease individuals… is keeping them out of the hospital more."

**Phil Gaziano, MD**  
President, Accountable Care Associates

"The contract is a way to support us as a physician group to help provide better care for our patients and care at a lower medical expense."

**Richard Lopez, MD**  
Chief Medical Officer, Atrius Health

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