Three strategies payers can use to control medical costs and improve the quality of healthcare

Changing the game: The next-generation care management model for payers

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In this world nothing is certain but death and taxes—and to add to the truism—the escalating cost of healthcare. The days of payers automatically passing through cost increases to employers and members are over. Even before the worst of the recession, the employer-sponsored insurance market declined by 1.6 million enrollees between 2007 and 2008. If payers don't take action, the vise on their bottom lines will continue to tighten—with lower margins squeezing on one side and declining membership rolls on the other. At a more macroeconomic level, the failure to contain costs may even exacerbate the call for a strong public option or a single payer in the next round of healthcare reform.

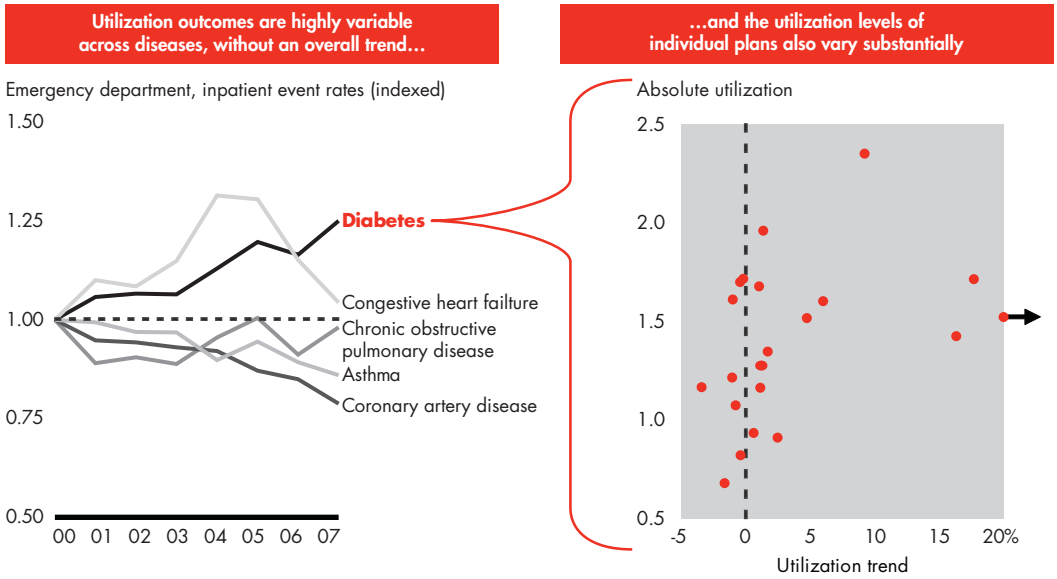
Despite the building pressure, payers find it hard to escape this predicament because they have limited options. In terms of paying healthcare institutions, they know it is unrealistic to expect any substantial improvement in pricing any time soon. In fact, healthcare providers are very likely to seek even higher payments from health plans to offset the reimbursement gap caused by the likely increase in public-sector patients. And on the administrative cost front, payers have already made significant improvements in recent years and will find it hard to squeeze costs more.

In the future, therefore, payers will need to focus on the toughest changes of all: reducing the need for medical care and lowering the cost of care delivery. Plans currently spend approximately 15 percent of their total administrative costs on traditional medical management—managing payments, managing the network, designing the plan, and disease and case management—but most have not been able to significantly or consistently reduce utilization (see Figure 1). We believe payers can make significant strides in reducing care-delivery costs. But this will require a transformational approach to managing healthcare; tinkering on the edges will not be sufficient.

In a recent research initiative, Bain studied more than 125 medical management programs in the US to identify what succeeded and what failed in the efforts to lower costs through improved care management. In most cases, we found that the major cause of poor utilization control is the payer's siloed and reactive approach to medical management. Typically, payers act like hockey goalies without defensemen, seeking to deflect every shot any way they can—using a glove (prior authorization, for example), a pad (utilization review), or a stick (a disease-management call center). Often, there are too many shots to deflect—and many find their way easily into the net. For payers, this means hundreds of unnecessary or duplicate tests, conflicting courses of treatment for patients, and small problems growing into much more expensive ones. Our research shows that instead, payers should invest in "defensemen"—in this case, members and providers. The former can help by managing their own health better and making better choices when they seek care; the latter can provide support by delivering and coordinating care in a lower-cost manner.

To move to this very different approach to care management, payers should focus on three main levers.

Figure 1: Historic payer investments in care management have not improved utilization



Note: Absolute utilization measured as emergency department and inpatient events per 1000; Utilization trend measured as CAGR of emergency department and inpatient events per 1000
Source: Disease Management Purchasing Consortium (21-plan benchmark database)

1. Revolutionize member incentives

By strengthening member incentives to manage their own health better—and by developing incentives that motivate members to participate—payers can dramatically lower the need for costly care delivery. While payers have been reticent to design and enforce strict incentive mechanisms for their insured members, there is proof that the idea works: Several self-insured employers have taken the lead in designing the right incentives and successfully implementing them through carrot-and-stick mechanisms. In our study, we found that self-insured employers who are leaders on this front attacked medical costs in three main ways:

- ***Motivating behavior and lifestyle changes for primary and secondary prevention:*** Historically, many employers invested in primary prevention through initiatives such as wellness programs because it was motivational for employees and was accepted as "the right thing to do." But a quicker route to reducing utilization is managing chronic disease. Over the last 20 years the answer to chronic diseases has been "disease management"—which has a mixed track record at best. In part, this is because these efforts were seldom coupled with financial incentives to bring about a change in patient behavior.

  Best practices are now changing that. On the primary prevention front, the first generation of such incentive change was educating employees on self-care. Pfizer, for example, provides employees with cash incentives if they complete health risk assessments (HRAs). The second gener-

ation of incentive structures goes further, including "sticks" as well as "carrots." At PepsiCo, for instance, employees who smoke pay a penalty of $600 (the company also offers a smoking-cessation program), while IBM employees who regularly exercise get cash rewards of $150. A few companies like Safeway have started the third wave of sharply focused incentives, linking premiums to the biometric reports of employees. Overweight employees who have high blood pressure and lipids, and who continue to smoke, have health premiums up to $800 a year higher than those with healthier biometrics.

Secondary prevention is also evolving. For example, many companies have begun implementing value-based benefit design. Here, patients are financially motivated to make choices that are likely to reduce overall medical expenses even if the payer, or employer, faces higher immediate costs. Pitney Bowes, for example, reduced members' share of payment for drugs used in treating three chronic conditions—diabetes, asthma, and hypertension—an average reduction of 50-85 percent in the cost of a 30-day refill, according to the Center for Studying Health System change. Since the program's introduction, Pitney Bowes says it has observed reductions in direct medical costs, sick-leave, and disability rates—all of which combine to outweigh the increased employer share of the drug cost.

- ***Incentives to choose particular providers:*** Many large employers (and health plans) have started tiering their networks based on quality and efficiency. Hannaford, for example, identified a network of doctors that provide high-quality care at low cost. To encourage use of this network, Hannaford pays a higher share of the medical costs associated with visiting these doctors. Payers too, are beginning to gain traction here. For example, Aetna has developed a network similar to Hannaford's for members in certain states. This Aexcel® network comprises the most efficient and lowest-cost physicians in the 12 highest-cost specialties in the broader Aetna network. Members are financially motivated to use these physicians based on co-insurance rates that are 10–20 points lower and co-pays that are often half as large.

- ***High-deductible health plans (HDHPs):*** Studies show that increased consumer financial responsibility reduces both healthcare use and spending. As a result, high-deductible health plans, (defined here as plans in which a person must pay at least $1,000 out of pocket annually before the plan pays a share of the costs) now represent 22 percent of all covered employees, up from 10 percent in 2006, according to the Kaiser Family Foundation. This mechanism could result in both limiting the need for care and improved provider choice. However, since these plans don't provide immediate financial incentives for healthy living, HDHPs end up accomplishing many of the same goals as the tiered networks described above. For example, by employing an HDHP and contributing $1,800 to a Health Savings Account, Whole Foods Market has made the total cost of care transparent to employees as opposed to being shielded by the traditional co-pay system. As a result, employees choose the lower-cost option more often.

Memo for action

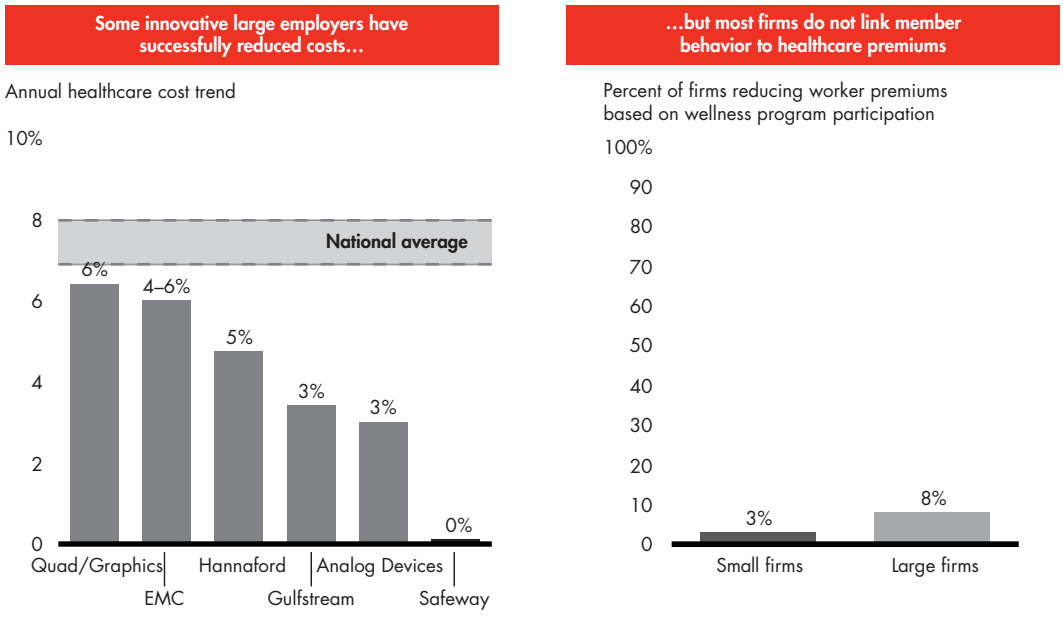
With a majority of healthcare costs tied to lifestyle choices, implementing stricter behavior-based incentives is critical. While there is no perfect formula, as a starting point, can payers double the amount of incentive dollars currently "in play" for each member—and double the percentage of members using those incentives?

Based on these successful programs, we believe that payers would benefit most from the following best practices: linking member actions directly to financial consequences; using both sticks and carrots; motivating members to manage their own health; tiering networks based on quality, efficiency, and cost; and involving healthcare providers in ways that reinforce the incentives. There is plenty of room for improvement for payers on this dimension: Currently only about 3–8 percent of employers link premiums to even participating in a wellness program, let alone health outcomes. And there is considerable incentive to do so. While national healthcare costs have increased by 8–10 percent a year, several innovative companies have succeeded in reversing that trend markedly: Quad/Graphics (reduced annual healthcare cost increase to 6 percent); EMC (4–6 percent); Hannaford (5 percent); Gulfstream (3 percent); Analog Devices (3 percent) and Safeway (0 percent) (see Figure 2). Self-insured employers may have been the pioneers but they needn't be the only settlers on the frontier. Nothing prevents payers from replicating this success with their fully-insured customers.

2. "Get out of the middle" on patient care

Payers can improve the delivery of healthcare—and manage costs better—by holding providers more accountable for the care of chronic patients. In our experience, 25 percent of a payer's membership base, on average, is chronically ill and this subset accounts for approximately 55 percent of an insurer's medical cost base. For most payers this is the core they need to focus on: By changing provider incentives and helping them adapt to be more responsible for patient care and cost of care, payers can slow the trend of rising healthcare costs.

Figure 2: Payers have significant room for improvement in tying behavior to incentives



Source: Kaiser HRET 2008

Reform should serve as a catalyst

US healthcare reform—including expected revisions over the coming years—will not rein in the escalating cost of healthcare in the private sector in the short term because it touches very lightly on payment reform and does very little to arrest the rising cost trend. What's more, reform is actually likely to exacerbate the need for payers to improve utilization and medical costs. Consider:

- Exchanges (with defined benefit packages) will further commoditize the individual and (potentially) small group markets, raising the importance of low-cost care delivery. On the Massachusetts exchange, the previously uninsured population disproportionately selected lower-cost plans.

- According to a recent Milliman Inc. study, annual healthcare spending for an average family of four is $1,788 higher than it would be if Medicare and Medicaid paid hospitals and physicians rates similar to those paid by private insurers and employers. A reform-driven shift of lives to Medicaid will likely increase this cost-shift even more, forcing private insurers to reduce utilization to maintain margins in the face of pressure to keep premiums down.

- Self-insured employers will increasingly turn to their carriers to help stem the tide of costs. Plans that can partner with receptive clients—and overcome their resistance to innovative measures like stricter incentives and tiered networks—will succeed and build competitive advantage in their markets.

Finally, it is very possible that health plans will face even greater regulation—and potentially a very strong public plan—in the next round of reform if they can't find a way to rein in costs. In an extreme scenario, payers could even be reduced to public utilities, serving as claim processors for a single-payer system. So, for both micro and macro reasons, controlling medical costs through improved care management is critical for private payers.

Memo for action

Can a payer enroll at least 25 percent of its severe diabetic or congestive heart failure members in a patient-centered medical home—within five years?

In our study, we found that programs in which payers stepped out of the way and allowed a coordinated group of providers to manage care for chronic patients without interference had greater success in lowering costs than programs in which payers sought to exert greater control. When the payer moved to a behind-the-scenes (though, substantial) role, physicians were able to manage the patient's complete needs, coordinate with other care-givers when necessary, and deal directly with the patient. As they do on strict incentive design, private payers often trail on this dimension, however. Now, with the increasing popularity of "accountable care organizations"—Medicare pilots, legislation and so on—the time is right for private payers to adopt bold, new approaches.

While there are a number of models for "getting out of the middle," our research shows that patient-centered medical homes (PCMH) can be among the most effective for managing chronic patients. Medical costs in these arrangements tend to stay better under control for four main reasons: There is a single physician in charge of the patient; there is often strong supporting infrastructure, such as IT systems, that help share patient data; the care is very patient-centered and encourages shared decision making; and the payer is usually able to set up the right incentives to ensure providers offer quality healthcare at reasonable costs.

Currently, multiple PCMH pilots are underway across the country and some have already begun to register promising cost savings. In 2005, BlueCross BlueShield of North Dakota (BCBS-ND) partnered with Meritcare Health System to coordinate the care of 192 members with diabetes. The medical home assumed control over educating patients, encouraging preventive tests, tracking care needs, and intervening when necessary. To align incentives, BCBS-ND employed a shared-savings approach with Meritcare. The PCMH approach worked well on several fronts: Utilization decreased, member health outcomes improved, and savings amounted to more than $70 per member per month (PMPM), or around 10 percent of the costs per diabetic (see Figure 3).

The PCMH experiment conducted by New Jersey's Horizon BCBS differed slightly. In this case, the company relied on a third party to coordinate efforts among physicians and other providers and suppliers. By ensuring good coordination for diabetic patients, Horizon succeeded in reducing total healthcare costs for pilot patients by about 10 percent.

While providers clearly take on much greater responsibility in this model, payers play a substantial role, too. For this approach to work, care coordination must go hand-in-hand with payment reform; only then are incentives aligned in a way that appropriately rewards providers for their increased risk. Specifically, payers and providers need to commit to a system of payment that rewards high-quality, coordinated, low-cost care.

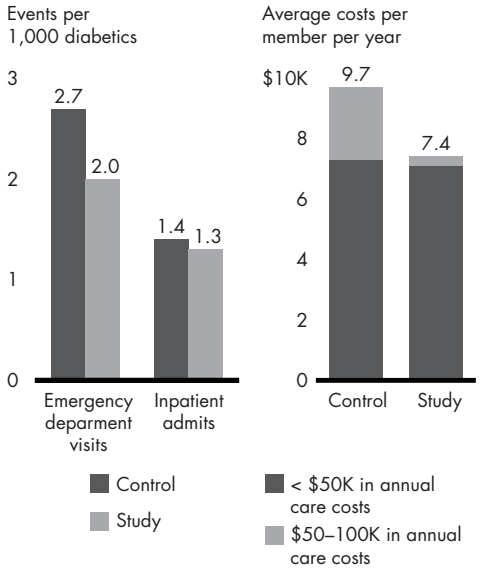
BCBS Massachusetts' Alternative Quality Contract (AQC) is a bold step in this direction. It pays a "global fee" to a set of physicians that coordinate a patient's care; if the group spends less than this amount, it retains the surplus. In addition, physicians receive a 10 percent bonus if they meet certain quality targets (process, outcomes, and patient experience). This ensures that physicians do not deliver less care in order to retain more of the global payment as margin. According to the BCBS-MA, it has nearly 25 percent of its HMO covered lives enrolled in the AQC today.

Figure 3: Innovative PCMH pilots demonstrate significant savings

BCBS-ND program...

- Diabetics visit personal care physician and are **auto-enrolled into the plan**
- Doctor **creates care plan** and refers to care management nurse
- Meeting with nurse is **face-to-face** for coaching on medications, care plan, etc.
- Nurse **tracks progress** versus goals and **schedules phone follow-ups**
- Physician compensation is **fee-for-service with sharing of savings**

...reduced utilization and costs



Source: BlueCross BlueShield of North Dakota (BCBS-ND)

However, the AQC is not without its challenges. First, members don't always understand that they must use the AQC sub-network, causing confusion and potential member dissatisfaction. Second, many providers are not sure they have sufficient systems, knowledge, or internal leadership to support this arrangement. To develop this model further, therefore, payers need to address the major impediments providers face in being able to manage a global payment-type arrangement (see Figure 4). In our recent interviews with providers, they identified several gaps in being able to manage such arrangements:

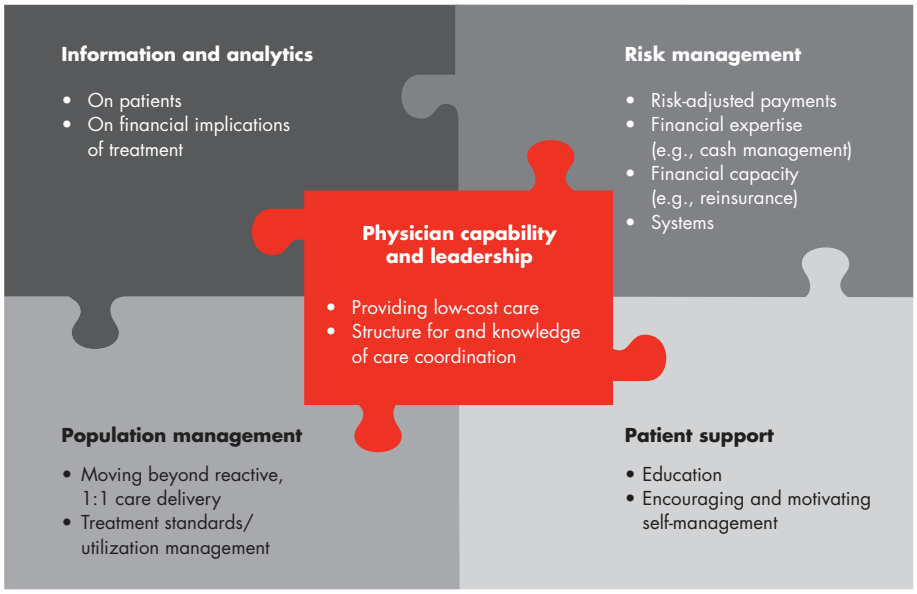
- Physician groups lack capability and leadership in delivering low-cost care;
- Physician hospital organizations (PHOs) or integrated delivery networks (IDNs) do not structure appropriate incentives for individual physicians;
- Information on patients and the financial implications of treatment are not available;
- Risk management capabilities, including ensuring properly risk-adjusted payments, are lacking;
- Population management tools, including treatment standards, are either unavailable or under-utilized;
- Patient support infrastructure—specifically, education and encouraging and motivating self-management—is under-developed.

BCBS's AQC is addressing many of these issues by providing information and consulting support to providers, facilitating best-practice sharing across providers, and tracking providers' process and outcomes. However, for the PCMH model to work, this list must be augmented

Memo for action

Can a payer reduce its traditional disease management spending by 25 percent—and use the dollars instead to invest in data and patient monitoring technology that provides a holistic, transparent view of a patient's needs?

Figure 4: Most providers will need to invest to build capabilities for global payment



further. For example, payers need to provide more support on managing risk and member incentives: Behavior change is just as important when members are in a global payment model as it is in a more traditional fee-for-service model.

Some of the necessary elements are more valuable than others. In recent interviews, for example, successful payer-provider integrated systems such as UPMC and Geisinger attributed a significant portion of their success to deep and seamless information- and capability-sharing between the plan and the delivery system. This is becoming more accessible for non-integrated payers, as well. Firms like Availity, Emdeon, and NaviNet have already built the "pipes" to transmit financial information between payers and providers. Some are now investing to use these pipes to transmit clinical information that clinicians can use real-time at the point-of-care to improve care and reduce cost. For payers who successfully want to "get out of the middle" and make global payment arrangements work, focusing on information sharing and ensuring that adequate investments are made in supporting providers will be critical.

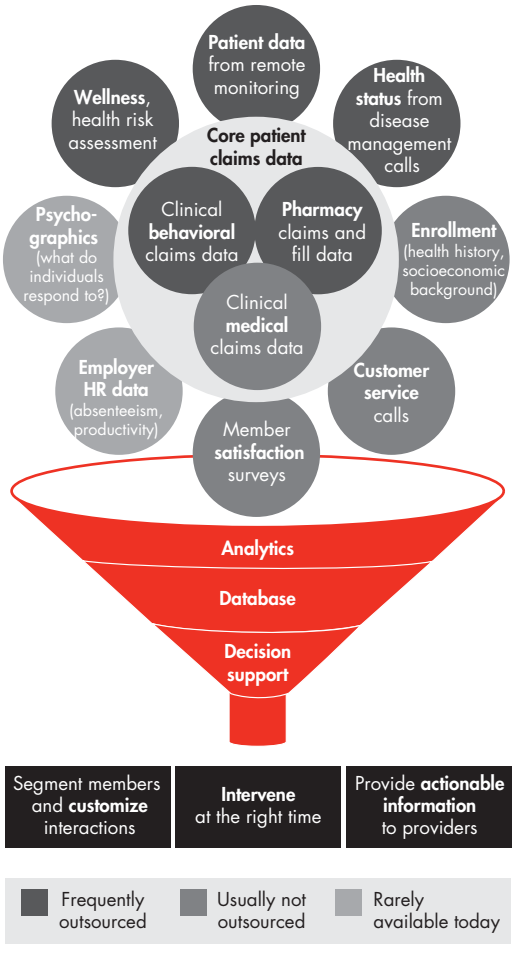
3. Make structural investments in information and systems

Payers can get the most out of member incentives and new provider arrangements by collecting and analyzing better member-level information. In the first two levers, we saw how valuable information can be in designing the right incentives to motivate patients and to aid providers in achieving the highest-quality and lowest-cost care. But despite investments in information technology—including significant investments in interoperability and interconnectivity—payers still struggle to collect and make use of the necessary informa-

tion about their members: Often, it is fragmented and held by different parties (see Figure 5). For example, pharmacy, wellness and mental-health data is often held by outsourced providers and not integrated.

This information gap then manifests itself in two ways. First, data is seldom available in real time. Even now, payers rarely know that a patient has filled the same prescription at two different pharmacies until they reconcile data weeks later. Second, even when some data is available in real-time, payers are forced to apply one-size-fits-all solutions rather than develop targeted strategies for managing chronic members. This allows both overuse of care and gaps in care, both of which prove costly.

Figure 5: Plans should find ways to integrate and apply data to improve member health



The first issue—lack of actionable, real-time, patient information—can be overcome with a combination of new and existing technology. Consider Quantum Health, a $10 million member-services and benefit-design firm that works in partnership with claims processors to provide full plan administration services for employers. Members are encouraged and financially motivated, via plan incentives, to call Quantum Health for both clinical and member-service guidance. When a member calls, nurses and medical directors use real-time data to channel the patient to the right referrals, the lowest-cost care, and health education. Quantum has reduced costs for its clients by identifying overuse of the Emergency Department (ED) and coaching members on when to use the ED; increasing use of PCPs before visiting specialists; preventing duplicative tests and services before they occur; recognizing conditions presented by members telephonically and directing care accordingly; and reviewing each inpatient case every day to help transition to long-term care as soon as possible. Through these mechanisms, Quantum is able to generate reductions in both inpatient admissions and average length-of-stay. These reductions would generate gross savings of 15–20 percent on inpatient costs in a typical population, and Quantum shares these savings with its employer clients.

Our research shows that the second major use of data and technology should be focused on member engagement that increases self-

management both pre-emptively for healthy patients and during chronic disease care (both outside of and inside PCMH-type arrangements). Not surprisingly, members respond to different offerings and psychological inducements, so tailoring messages is critical. A University of Oregon study that targeted members with chronic illness in LifeMasters' DM program used technology to assign each member a Patient Activation Measure (PAM), which was calculated based on the patient's knowledge, engagement, and propensity to change behavior. Patients at a particular PAM score received specialized coaching focused on realistic activities for improving the health of the patient based on what they would or would not respond to. In the study, the treatment group saw a sharp drop in utilization—a 33 percent decline in in-patient admissions and a 22 percent decline in emergency department visits.

Generating this improved level of engagement is not easy, but payers are now experimenting with some low-cost, high-tech approaches that can help. MVP Health Care, for example, sends lists of diabetic members who are missing their tests to Eliza Corp., a company that employs an interactive voice-recognition system. These patients receive automated calls from Eliza, which confirms the identity of the patient, provides health coaching, and links patients to live health-coaches if needed. The Eliza system is interactive and adaptive, engaging the patient based on his or her responses rather than applying a one-size-fits-all approach to member health management. MVP's effort is paying off: Its diabetes patients have increased their annual test frequency and are reporting better control of their health.

Next steps for payers

Transformational change is never easy, but this change is critical for the healthy survival of the managed care industry. To begin this care management transformation, we suggest thinking through the following Care Management Diagnostic for your organization:

- What are the biggest near-term care management improvements the organization can make before developing the longer-term system? What is easily achievable?
- What medical cost opportunities are greatest in size and accessibility?
- What would be the key components of a next-generation care management model given the organization's member and provider base? How would the key components be linked together? How would this new model increase the strength of incentive structures, help in "getting out of the middle" where appropriate, and improve the collection and use of member-level information?
- What constraints (e.g., local market structure, existing strategies) exist? How would these constraints hold back the optimal system? How can they be overcome?
- Which required capabilities, systems, and approaches are present in the organization today? Which capabilities would need to be built or acquired to implement the model? What investment would be required?
- How could potential partners (e.g., other payers, technology firms) play a role? Where would they be most valuable?

An even bolder move for high-share payers?

Our next-generation care management model requires major investment and, we believe, can make a significant difference in arresting rising medical costs. But payers that have very strong positions in a market—especially markets in which providers are not willing to, or able to, be accountable for the cost of care—could push the envelope even further by integrating forward in the healthcare value chain, into primary-care delivery. There is already a need for greater primary-care access, and that is likely to grow more acute as coverage expands.

This forward integration could take different forms. For example, a payer could employ a set of physicians and physician extenders (registered nurses, physician assistants and so on) and set up clinics at major employer-customer worksites or free-standing clinics. Or a payer could partner with a retailer to run a clinic within a large, centrally located store, as many hospitals and physician groups are already doing at select Walmart locations. Regardless of the mix of sites, a seamless electronic medical record maintained by the payer would link the sites and the powerful informatics engines behind the scenes.

To be sure, there are hurdles to clear. For example, the economics of this model particularly suits payers with significant local market share. In addition, payers would need to think about channel conflict with primary-care physicians, especially if they are closely allied with large integrated health systems. Finally, payers would need to add physician capabilities to their toolkit. However, if the right payer were to clear these hurdles, it would control medical costs more directly.

- What capabilities can local provider partners bring to bear? What gaps do they have? Which capabilities can the organization help providers build?
- What organizational changes might be required to reach full potential in the new model?
- What pilots are required and how should they be scoped?
- What current care management efforts could serve as the foundation of broader care management pilots or programs?

In our experience, the Care Management Diagnostic provides payers with a very practical approach to improving their ability to slow the trend of rising medical costs. Historically, payers entrusted their medical management organizations with most—if not all—of the responsibility for controlling utilization. These medical management organizations, in turn, tried to control utilization with very blunt instruments like traditional utilization review and prior authorization because they had no control over more robust instruments, such as member incentive/benefit design (reason: embedded in business units), provider relationships and payment (often housed within a Provider Relations group), or the ability to truly engage members (completed by the business units, if done at all).

In the future, these three parts of the organization—product, benefit and incentive design; network contracting and payment; and traditional medical management—must work together in a consistent fashion with a clear strategy. At the very least, this means improved coordination among the owners of these levers. To wring out the most savings, payers may need to consider organizational moves that take them out of their comfort zones. That is therefore a challenge that must be championed by top leadership. Only a CEO or COO can drive transformational change and ensure that executives and staff work across silos, better coordinate systems, integrate data and technology, and align the entire organization on a single goal: to provide quality care at a lower cost.

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