UNDER THE microscope

By Christian Moreno & Bruce Sammis

REVOLUTIONARY INDUSTRY DATA-SHARING HELPS EMPLOYERS UNDERSTAND TOTAL COST OF CARE

If your company operates a **SELF-FUNDED MEDICAL PLAN,** be prepared to **DRAMATICALLY CHANGE THE WAY YOU LOOK AT COSTS** and evaluate your plan's performance.

As most HR pros and CFOs can attest, ensuring compliance with the rules and regulations of the Affordable Care Act (ACA) hasn't been easy, and it could become even more complex if the ACA is repealed. However, the noise surrounding the ACA has overshadowed a significant development in the health care industry that deserves employers' attention.

For many years, actuaries and analysts have worked together in the Uniform Data Systems (UDS) Group, an industry consortium composed of the nation's largest health plans and consulting firms. Carriers agree to provide data that conform to UDS data standards, ensuring comparability across carriers. Consultants receive the same data; differentiation comes from how the data is used.

The goal of the UDS has always been to analyze and share claims data and network discounts, but the data being passed around was fairly general – until now.

Game-Changing Data

The UDS has not only captured much more detailed and significant data, but it has also developed new ways to use this information to evaluate a health plan's efficacy as it relates to cost. This is especially important for the growing number of employers that have chosen self-insured medical plans in response to the ACA. Cost is relevant to all employers, of course, but those that are partially or fully self-insured stand to benefit the most from the new data and analysis.

Why? The concept, called Total Cost of Care (TCC), turns on its head conventional wisdom about which health plans are the right "fit" for which employers, and demonstrates that the commercial networks that *appear* to be similar on the surface are not. Moreover, the larger commercial network discounts don't always equate to the best value for an employer.

To understand why TCC is so revolutionary in today's health care climate, you must first understand the evolution of the health plan network.

The "Network" Myth

When evaluating health plan options each year, one of the most common questions employers ask is: "How good is the network?" While "good" is a relative term that largely depends on what is most important to a particular company, it typically means that the network:

- includes a broad choice of quality doctors,
- provides a sizeable discount, and
- requires the smallest number of employees to switch providers.

For decades, carriers have tested out different models and refined how their networks operate in an attempt to reduce costs and differentiate themselves in the marketplace. Many trace the roots of managed care back to the 1920s and 1930s when the concepts of prepaid insurance and "network" access were first introduced. Baylor Hospital in Texas, for example, offered comprehensive health coverage to 1,500 teachers for a fixed premium, creating the first "Blue Cross" plan (and network).

Regional health maintenance organizations (HMOs) launched in the 1960s and 1970s, playing a relatively small role in health care delivery and financing. Then, starting in the 1980s, HMOs exploded in popularity – fueled by a favorable legislative climate and a rich benefit/cost ratio for employers and employees. It was during this era that the term "in network" became synonymous with "good" from an employee standpoint. HMOs had very tightly managed networks, either through employing physicians directly or paying a capitation fee to physicians based on covered lives. These plans had very limited (if any) out-of-network benefits.[1]

By the mid- to late-1990s, the HMO backlash had begun, mostly because the HMO models were viewed as too restrictive in both access to care and size of networks of providers. Two other forms of managed care financing/delivery quickly filled the void, and employees happily moved to point-of-service (POS) plans and preferred provider organizations (PPOs). (See Exhibit 1.)

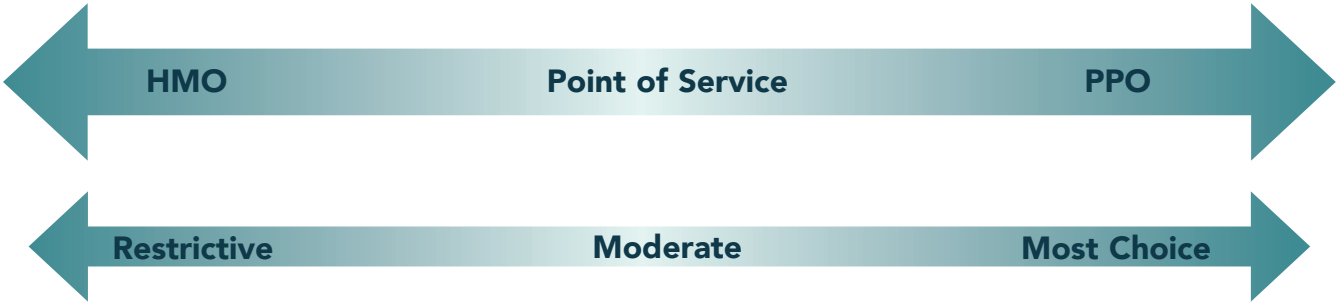
The wider network of the PPO managed care model that gained steam in the 1990s was a direct response to the HMO era's lack of choice, but at what cost? The very premise of the PPO – large networks and freedom of choice – has led to inclusion of so many physicians and hospitals in each network that it has diluted the notion of a "discount."

Plans are often marketed based on the size of their networks, and almost unlimited access and choices are offered to members. This begs the question: Is it really a network if 95% of all available hospital beds and 85% of the physicians and practices are "in network"? At what point does a network become simply a retail price with a third party financing the bulk of the cost?

Moreover, what is the value of a network if everyone is included? Essentially, with so many providers and hospitals in the network, the PPO discount is simply a reduction of a mythical price that no one actually pays.

To truly analyze and understand a carrier's network value proposition, employers today must look far beyond ***who*** is in their network and ***how much*** these providers charge. They must be able to actually evaluate the network's efficacy, as it relates to its costs.

EXHIBIT 1:
Managed Care Spectrum



Credit: Lockton Health Risk Solutions

Over the past 10 years, employee benefits consultants and analysts have been able to analyze the broad discounts offered by various carriers/networks in a given location, and in turn compare and make recommendations for employers on who "wins" the discount battle.

This high-level analysis of negotiated discounts in a given locale, however, is only a small part of the equation. Networks and carriers' use of cost and quality control tools such as utilization management, physician referral, patterns, and disease management are significant and could have a consequential impact on the *actual* costs of the network.

The UDS Group determined that employers needed access to *all* claims and cost data in very specific geographic locations in order to present a deeper and much more meaningful financial analysis. Thus was born the idea of helping employers understand their Total Cost of Care.

Total Cost of Care: A Microscopic Look at Cost Factors

In the current health care system, logic would suggest that for two identical groups with identical risks, identical disease profiles, and identical demographics that were both seeking care from two roughly identical networks, the TCC provided for each group should also be identical. But it isn't.

These discrepancies in cost are the premise behind TCC. Total Cost of Care focuses on *why* and *how* the costs and protocols inside the network yield different results for different employers.

TCC helps employers evaluate the financial performance of their health plans by taking a microscopic look at the *actual* costs of health care for a given population – with each respective insurance carrier.

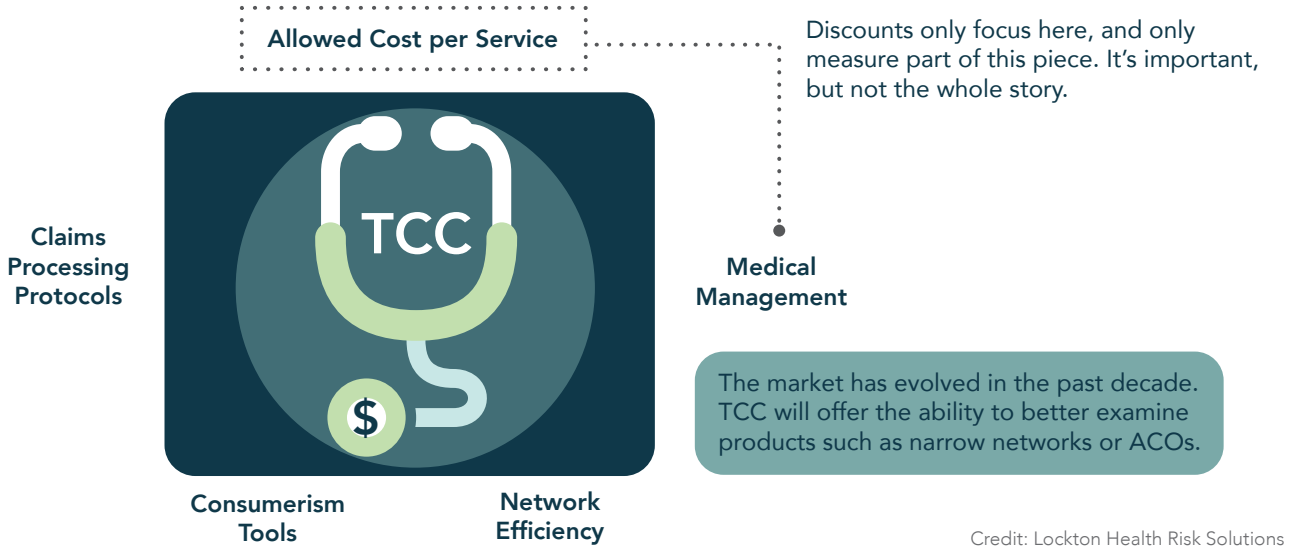
Companies have long tried to compare plans by the network discounts offered, without fully seeing all of the factors that impact costs. The current "raw discount" comparison used to make decisions fails to distinguish some key differences in the comparative networks/carriers.

Differing demographics, provider mix, physician referral patterns, and carrier/network discount calculation nuances can cause misleading or even erroneous results.

Further, there is currently little – if any – contemplation of disease management/clinical efficacy/outcomes in the discount analysis.

As shown in Exhibit 2, TCC takes a more holistic approach to cost analysis, examining factors that are typically hidden in a normal network comparison but that could be driving up the cost of the plan for an employer. It allows employers to

EXHIBIT 2:
Why Change? Total Cost of Care Variables



Credit: Lockton Health Risk Solutions

EXHIBIT 3: Old World vs. Total Cost of Care

Old World Discount Comparison

Allowed / Billed - 1

A

$50M / $110M - 1 =

55% discount

1.00 med decrement

B

$100M / $200M =

50% discount

1.11 med decrement

Total Cost of Care Calculation

Allowed / MM * Risk Adjustment^

A

$50M / $155K MM =

$323 PMPM

*** 1.10 RA**

= $355 PMPM

1.00 med decrement

Carrier A has a better risk than the norm, so risk adjustment must increase to the norm of 1.0

B

$100M / $300K MM =

$333 PMPM

*** 0.97 RA**

= $323 PMPM

0.91 med decrement

A WINS DISCOUNT GAME

B WINS LOWEST-COST GAME

^Technically, this is: Allowed / MM * Risk Adjustment + Capitation / MM

KEY: PMPM = PER MEMBER PER MONTH RA = RISK ADJUSTMENT MM = MEDICAL MANAGEMENT

EXHIBIT 4: Analysis Doesn't End at the Discounts

This exhibit demonstrates how Hospital B wins – and why the analysis is necessary.

Traditional Discounts

	Hospital A	Hospital B
Retail Price	$4,100	$3,200
Discount	60%	50%
Net Paid Per Day	$2,460	$1,600

Other Variables to Consider

	Hospital A	Hospital B
Admits Per 1,000	65	50
Average Length of Stay	4.0	4.6
Actual Cost	$639,000	$368,000

KEY POINTS

- Hospital A has better discounts and a lower average length of stay – yet significantly higher costs (loses the cost battle in the end). This would not be shown in a pure discount comparison.
- Employers cannot use isolated variables or statistics to judge a network's performance. Multiple variables that ultimately impact the performance and cost of the network must be considered.

compare carriers/networks by taking into account factors like the carrier's cost per unit, utilization, provider mix, network penetration, medical management, and claims protocol. The result is the most detailed look to-date at health plans and their *true* costs to a specific employer.

Comparing Networks: Is Apples to Apples Really Possible?

The first key to TCC's effectiveness is to ensure that all member data in a specific region is provided; general numbers from a carrier's overall book of business is no longer acceptable. TCC focuses on the costs of specific members in a particular location to get the most accurate data.

The second key to TCC is the calculation of a "risk score" for each carrier. It's worth noting that the UDS spent two years developing this risk score, and it encompasses nine disease classifications as well as age and gender. Let's take a more detailed look.

Revolutionary Idea No. 1: The Per Member Per Month Cost

Carriers now provide the claims data for their *specific* book of business in a given region – not just aggregate, general data. Now, employers can see exactly how employees in a given network and specific location "flow" through that network. Employers will have access to data including the providers these patients see, those they are referred to for additional care, the costs associated with those visits, hospital admission rates, return visits for complications, etc.

Now that this data is available, patterns will start to emerge. For example, a carrier whose medical management program continually directs people to the most expensive yet least effective health care providers will now become apparent in TCC modeling. Once employers are armed with this additional information, they may think twice about choosing a carrier or network – even if the discount price seems right.

Revolutionary Idea No. 2: The Risk Adjusted Per Member Per Month

Now that employers have more detailed, region-specific costs for each carrier, the goal is to compare carriers and networks against each other. If one carrier has younger, healthier employees, and the other is full of older diabetics, how can their per member per month (PMPM) costs be compared?

To accomplish this and truly make the comparison "apples to apples," the UDS came up with a formula to adjust for the risk based on diagnosis codes. Now, the data from any carrier can be adjusted to a 1.0 risk factor, and thus can be accurately compared across carriers.

This new, risk adjusted PMPM is unique because it actually reflects *two* stages of calculations – each stage contemplating a separate data set. The first set reflects claims paid per member and the other normalizes for risk/health variances for the entire carrier's book of business – by location. (See Exhibits 3 and 4.)

TCC Limitations

It's important to note that TCC is a new concept and has some limitations. Smaller, or accountable care organization (ACO) networks, many of which are being built on the premise of lower costs and better clinical outcomes, cannot yet be evaluated using TCC because the number of patients and claims volume isn't sufficient to satisfy the statistical validation of outcomes. These new models will take a "wait-and-see" approach as more data becomes available.

As the data set increases and TCC becomes a more common evaluation tool, the implications for both quality improvement and cost savings are promising. While pricing is currently limited to "Carrier A" vs. "Carrier B," a system that examines *entire* health care systems to compare on both cost and quality measures could evolve. This may lead to true health system competition by allowing choice at the member level.

As a result, employers that have historically been unwilling to limit access/choice in favor of lower costs may face some difficult decisions. If a narrow/high-performance network limits choice by removing 50% of the options in a given geographic area, and the result is significantly lower unit costs, will employers choose it? Time will tell, but the significant cost pressure on employers indicates that ACOs with narrow networks are on the upswing, and tools like TCC will not only help employers evaluate these networks, but may also help *create* them.

Will TCC Replace Current Network Evaluation Methods?

For now, conventional wisdom is to use TCC concurrently with existing systems, and health care consultants versed in new TCC methodology should provide both analyses.

TCC is not a silver bullet – just a better bullet. As the data grows, it could lead to a slow shift to pricing and network comparisons that could replace the long-running managed care network known as the PPO.

In many cases, an "old world" network analysis and a "new world" TCC analysis may yield the same recommendation for an employer. But in the case where the two methods yield different results, you'll want to dive into the data more deeply to determine which network/carrier is a better fit. For the fully self-insured employer, a big discrepancy in the recommendations could have a significant financial impact over the long term.

What's Next?

The market innovations in health care technology have come fast and furious. From transparency tools that allow members to price shop for health care to narrow/specialty surgical networks that carve out specific procedures in various locations to disease management engagement platforms that aim to engage members on a condition-specific basis, an employer's understanding of its true Total Cost of Care will become even more important.

TCC has opened a door and will shed light on the efficacy (or lack thereof) of the latest and greatest health innovations. Using historical data to view the actual, real results of the network or protocol in question will drive the networks that are more efficient and effective to new value-based consideration. In essence, true "managed care" may very well come back to win.

So, what's next for your company? Review your network selections and financial measures differently in the coming year. Knowledge is power, and TCC data puts employers more "in the know" than ever before. ■

Endnote

1. The Origins of Managed Health Care, Chapter 1. Jones and Bartlett Publishers, LLC, adapted from P.D. Fox and P.R. Kongstvedt, "Chapter 1: An Overview of Managed Care," in *The Essentials of Managed Health Care.*

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Total Cost of Care IN ACTION

Acme Contractor has 1,000 members on its health plan and is comparing Carrier A vs. Carrier B. The traditional network analysis produces a recommendation of Carrier A with better gross discounts, which historically was considered a "win" for employers. However, using new TCC analysis, Carrier B wins largely because of its overall network management and provider referral patterns. Essentially, the percent difference in the network access was irrelevant in the grand scheme of costs.

While TCC is not currently set up to establish quality measures or provide that raw data, we can infer by looking at the overall claims that certain carriers with significantly "better" TCC multipliers may have better disease/chronic condition management. This might be indicated by lower hospital admission rates or lower long-term costs for Type 2 diabetics, as an example.