Rethinking SPECIALIST CARE

EPISODIC BUNDLE, DATA MINING AND STOP-LOSS INNOVATION WILL HELP SECURE HIGH-VALUE, LOW-COST TREATMENT WITH SUPERIOR OUTCOMES

Written By Bruce Shutan

The decades-long pursuit of high-value, low-cost medical treatment delivered through self-insured health plans is elevated when it comes to specialist care. An analysis by the Institute for Health Metrics & Evaluation at the University of Washington suggests that it accounts for as much as 72% of the nation's total health care spending across the entire population.

A closer look at various trends help explain why this is the case. For example, hip and knee replacements have become increasingly routine with wild price variations complicating care decisions. Another area of consideration involves musculoskeletal disorders, whose total cost government research shows can be as high as $45 billion to $54 billion.

But that's only part of the story. An estimated 60% of U.S. adults have a chronic illness and 40% have two or more such conditions, according to the Centers for Disease Control and Prevention.

Among the leading drivers, which the CDC says costs an eye-popping $3.8 trillion a year, are heart disease, cancer, chronic lung disease, stroke, Alzheimer's disease, diabetes and chronic kidney disease. Few would argue with the notion that the U.S. has become an unhealthy nation.


Brian York

The key to managing these costly conditions and improving clinical outcomes is a partnership approach that combines data mining, episodic care with bundled prices, technology tools and innovative stop-loss products, industry experts say.

ALIGNING ALL KEY STAKEHOLDERS

"The biggest challenge is a lack of transparency in the system," observes Brian York, VP of value-based care at Coverys. "How do you know who provides quality care? How do you understand the differences between physicians or healthcare systems? It's not an easy task. It's very opaque to the consumer."

In securing the best possible care for patients at a reasonable cost, he says there needs to be an alignment between the insured, employer and physician, which will improve loss ratios and stabilize monthly premiums. With such great variability in quality and cost of care, he strongly believes health care consumers "deserve insight into that to help them make wiser choices."

One promising solution involves a bundled set of services to treat various conditions. Orthopedic surgeons have traditionally focused on filling up their OR schedule, perpetuating the practice of higher volume translating into higher profits. But in an episodic payment model, York says they're given a target price from preop to postop and everything in between with financial incentives tied to outcomes.

"If they do one knee surgery well, they get their surgeon's fee but also reap the upside of the overall savings for that episode," he explains. "They are actually managing the rehab and anesthesia costs."

Instead of just handing off patients, York says physicians will want to choose their downstream providers more wisely and stay connected throughout their episode of care in hopes of reaping greater cost efficiencies. That means choosing a rehab center with the lowest infection rate and a shorter stay, avoiding facilities that will bill for extraneous days just to rack up additional fee-for-service charges.

"An orthopedic surgeon that does knee surgery well can make more money doing fewer surgeries, as long as they are quality surgeries that have a quality outcome," he notes. By managing that continuum of the episode, the physician is incentivized to provide quality service. The price for the episode of care is spelled out as a fixed bundle payment to the provider, who he says is on the hook for the excess cost of care.

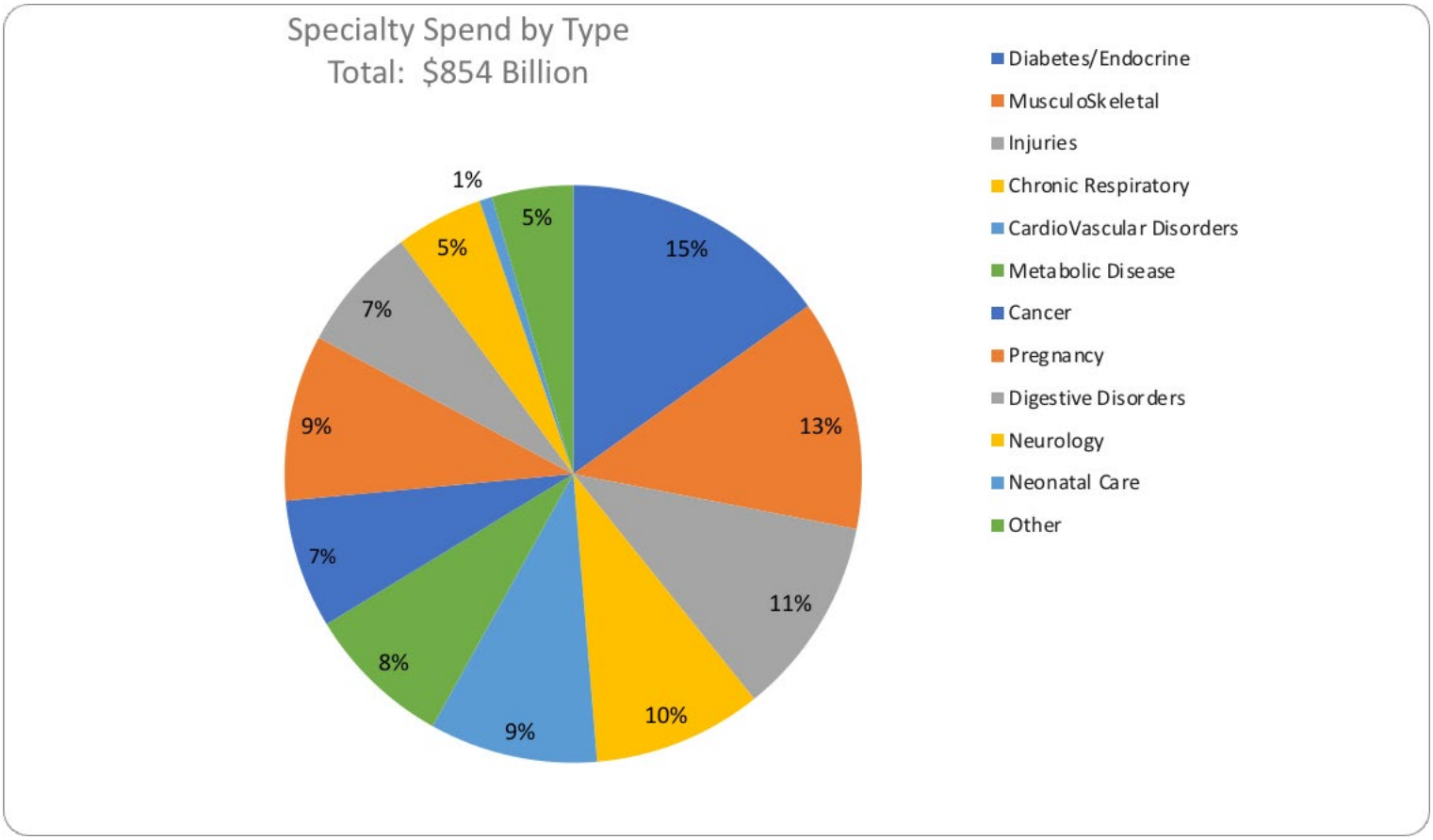
SHARING RISKS AND REWARDS

What makes an episode-of-care program so valuable is that it involves more sharing of information and risk, collaboration and much clearer expectations for what the process should look like, according to Dave Terry, founder and CEO of Archway


Dave Terry

Health. He says it also features a single entity or individual who's responsible for managing cost and quality, as well as patient experiences along the continuum of care. This improves the chance of a good outcome.

His firm has profiled every specialist in the U.S. and examined the total cost of care over an episode of treatment to both the employer and employee to match up the quality with the value. "We have a tremendous amount of data that we use to evaluate this," he reports.



One of the first things his firm looks for is expertise, whether it's knee replacement surgery, valve replacement or a stent, breast or lung cancer treatment, etc., as well as experience performing these procedures.

"Volume is not necessarily an indicator of quality, but it's necessary," Terry believes.

Other critical factors that must be considered include overall health outcomes, complication and readmission rates, hospitalization rates in certain case, end-of-life care – in short, a variety of different quality metrics that vary by type of condition or procedure.

What's important is that self-insured employers find ways to engage employees in this process and help them make wiser, more informed choices, according to Terry. "Some of that can be direct engagement through benefit design and the HR team," he says, noting how technology tools are facilitating that process. Another avenue is that primary care organizations increasingly are partnering with employers to ensure they're working with high-value, high-quality specialists, he adds.

York describes technology as the Holy Grail and future of health care, noting how scores of scrappy startups are disrupting the industry alongside established players such as Google and Amazon. In the stop-loss space, he says Amazon is actually giving away web services to health care providers and hospital systems in exchange for data.

"It will be interesting to see what they bring to market because they are not traditional providers or payers of health care," he notes. "They're going to use that quality and cost variation as an arbitrage tool."

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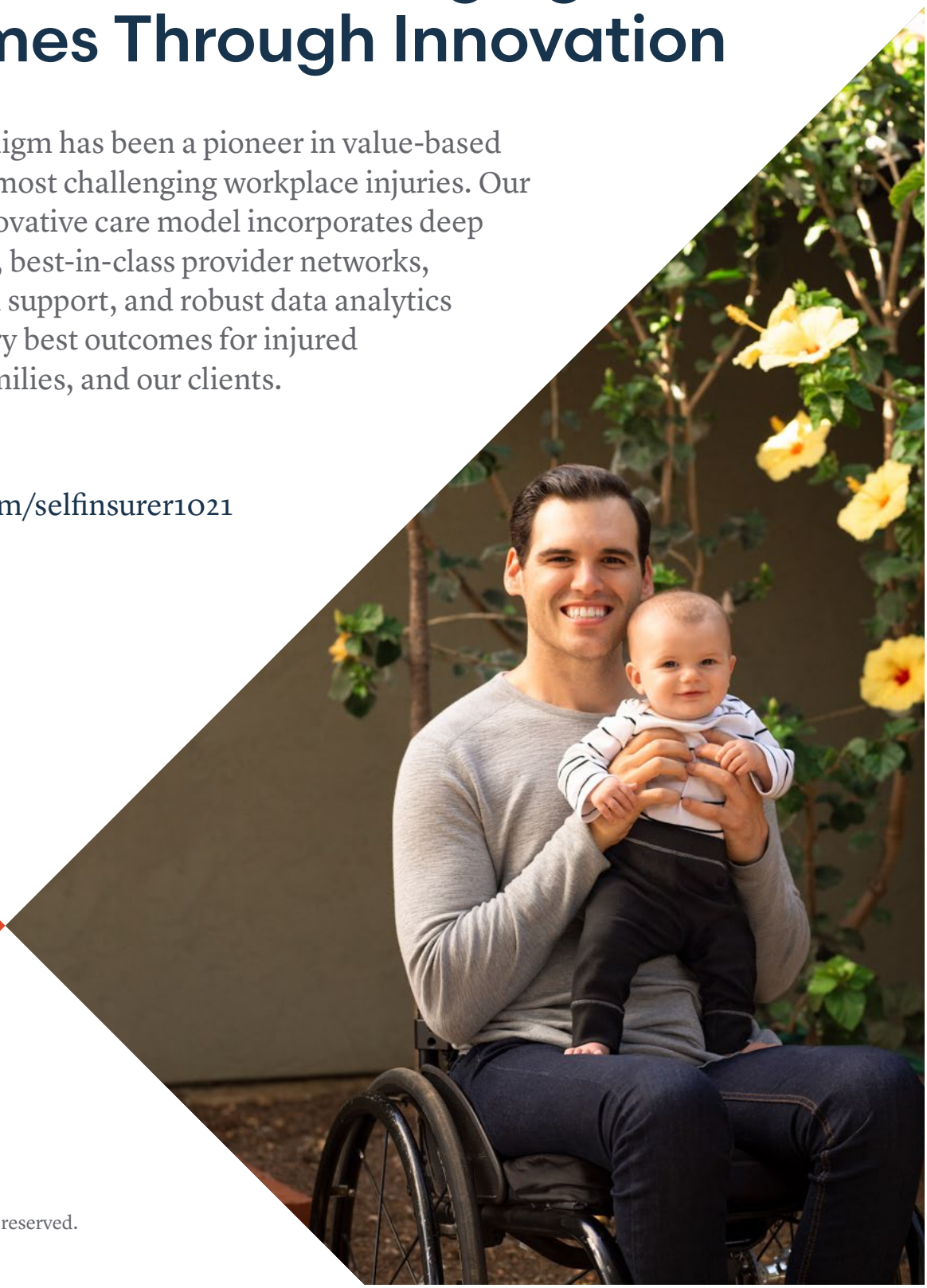


RAISING THE BAR ON STOP LOSS

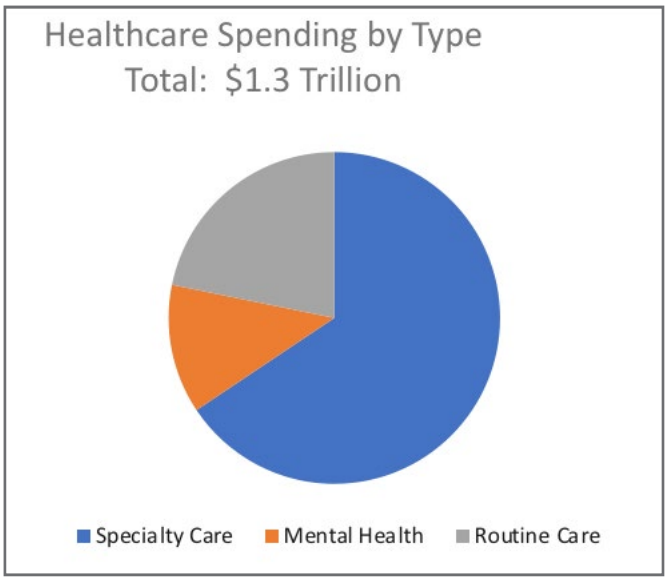
An impediment to managing specialty care has been lack of innovation in the insurance space. Stop-loss products, for instance, have generally been the same over the past 15 or 20 years, York notes. However, he's encouraged by more tech-driven products that analyze care patterns within a given network without regard to contractual relationship that a payer would have in order to find high-quality specialists.

Bundling standard insurance products will not only protect self-funded employers from runaway costs, he believes, but also arm them with the intelligence to make proper health care choices. "You have to link the two together to mutually benefit," he adds. "Self-funded employers are uniquely suited to do this and drive patient care to the best physician."

Archway Health has developed an aggregate product that Terry says creates an opportunity for employers and their employees to pay closer attention to the first dollar and manage the total cost of care below a total-cost deductible. It also arms patients with enough information to make wiser choices from the very beginning.

"It's really important to think about how every employee makes choices for any type of specialty care that they need because it's all building up toward the ag and attachment point," he explains. "When that happens, there's just a lot more engagement across the enterprise with people in the C-suite at the company, HR, and then coming in with creative ways to engage the employees and help them make wise choices."

Early engagement is the key. Terry says developing an understanding of market variability with respect to quality and total cost along the way to making better choices can help improve the whole process, including outcomes and patient experiences. "But you want to get engaged with everyone sooner," he points out. "In a spec product, it sort of pushes that decision out, but in an ag product, it really kind of gets everyone on the same page faster and folks working together and using information in new ways."



RESHAPING REFERRALS AND CARE DELIVERY

Citing a recent article in *The Wall Street Journal* that revealed C-section pricing at a Northern California hospital ranging from $6,000 to $66,000, Terry describes the massive variation as unbelievable and indicative of a deeply flawed marketplace.

Perhaps even worse is when patients choose costly facilities that under deliver. "We'll see examples where very high-priced organizations will have poor outcomes for certain procedures or conditions," Terry observes.

"There are very few multi-trillion industries left where the decision making, information and underlying contracts are so opaque," he laments. Still, he's sanguine about what lies ahead: "I think we're at the precipice of that changing pretty significantly over the next several years, and information flow is the key to changing the way health care is delivered and referrals are managed in our industry."■

Bruce Shutan is a Portland, Oregon-based freelance writer who hasclosely covered the employee benefits industry for more than 30 years.

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BENEFITS CONSULTANT PRACTICES WHAT HE PREACHES

As both a benefits consultant and employer with 95 associates who he cares deeply about, CGI Business Solutions President Dan Cronin says the quality of measurable data ranking specialists for the firm's nearly four-year-old self-insured health plan is critically important.

"We've experienced a very high degree of satisfaction with a program like this," he told attendees of a panel discussion about specialist care strategies at SIIA's 2020 virtual national conference. He referenced lessons learned from some cases involving low-level orthopedic care, lamenting a hit to the plan's reinsurance from complications associated with a roughly $75,000 knee-replacement surgery.

Dan Cronin

Cronin's company introduced financial incentives to steer health plan participants to the most affordable, high-quality care. Low-cost ambulatory surgical centers are built into a standard PPO-style plan with a $1,000 annual deductible for individuals and $3,000 for families, as well as a plan featuring a health savings account (HSA).
The challenge was incorporating this concierge service to drive it even further. Those who elected the PPO option and called a toll-free number that connected them to a nurse who would guide them to a lower-cost, high-quality provider received a $750 credit off their health reimbursement arrangement toward their deductible.

That meant the net-member responsibility was only $250. In taking it a step further, his company would waive the deductible on lab tests for those who used the service.

As for the HSA plan, a $1,000 reimbursement was applied on the back end of deductibles for employees who engaged a health care advocate so that they wouldn't lose their qualification to contribute to the HSA. And with a $125 monthly employer contribution to those accounts, the net out-of-pocket cost was just $500 for individual coverage.

"This type of arrangement is prevalent with all our self-funded groups," Cronin reported, noting the power of practicing what is preached. On a personal note, he was thrilled with the results of steering his mother to a top eye surgeon in the Boston area to repair a detached retina in her right eye and remove a cataract in her left eye with the help of this program. – Bruce Shutan