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FOR HEALTH TECHNOLOGY

# Insurers, Hospitals, and Consumers: Challenges and Strategies for IPAs

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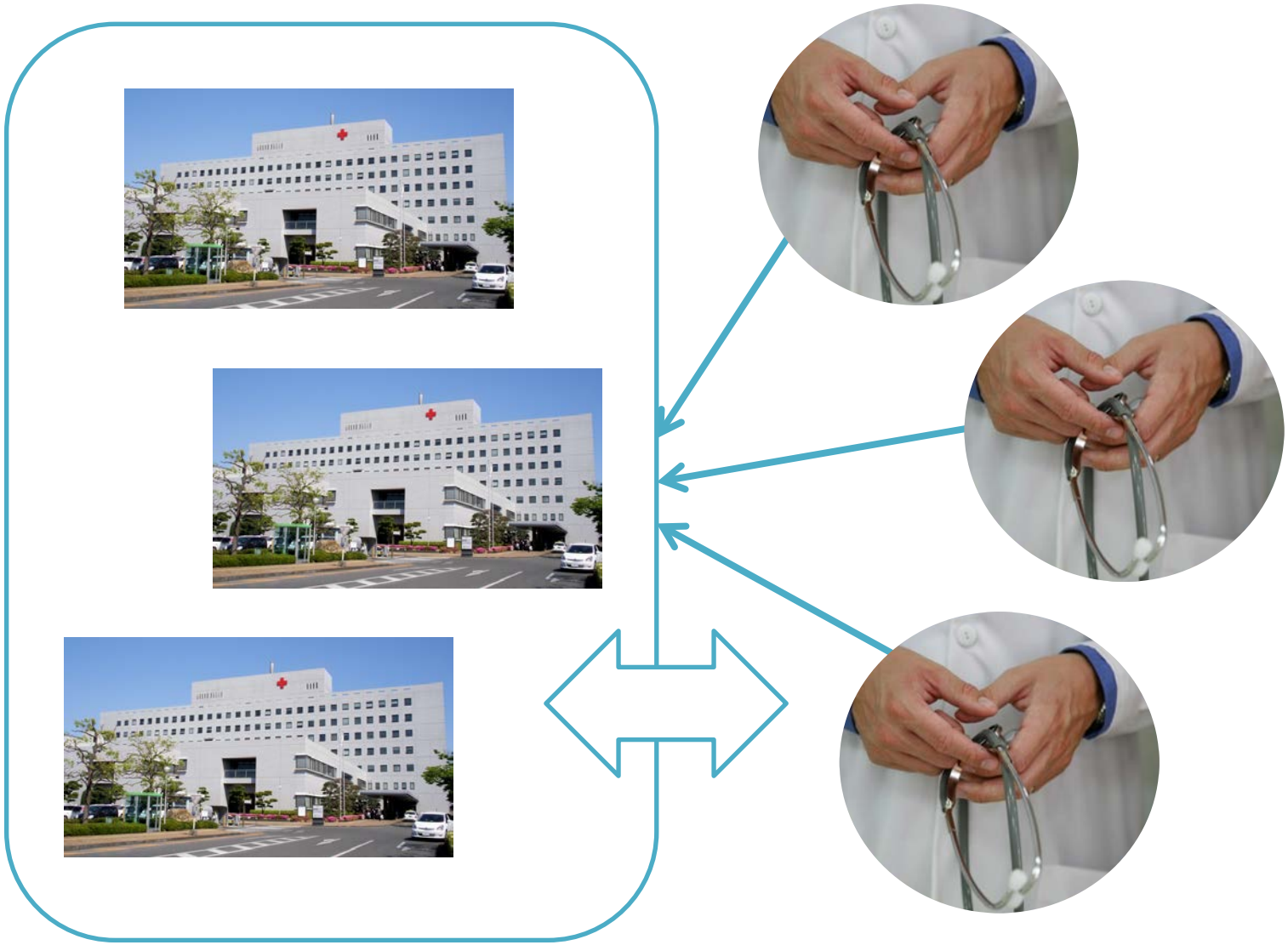
# Overview


- Hospital employment of physicians
- Evolution of insurer strategies
- Patients as consumers
- Are you ready?

# Integration Between Hospitals and Physicians:
## The Good, the Bad, the Backlash



# Potential Effects of Integration

1. Increased efficiency (lower cost, higher quality)
   - Can lead to regionalization of services, with higher patient volumes and better outcomes
   - Reduced costs of supplies, access to capital
2. Decreased efficiency
   - Large firms can become complex, slow-moving, resistant to change and innovation
   - Incentives for employees are weakened
3. Increased pricing
   - Integrated firms may obtain efficiencies but then not pass them to customers through lower prices
   - Integrated firms can lose efficiency and then need to raise prices to compensate

# What are the Potential Efficiencies from Hospital-Physician Integration?

**Improved assessment and purchasing of high-value physician preference items**

- Orthopedic joints and ancillary supplies
- Spine fusion implants: rods, screws, plates, etc.
- Cardiac rhythm management: pacemaker, defibrillator, CRT

**Improved coordination of care and discharge planning**

- Faster OR throughput, more cases per day
- Reduced LOS and readmissions
- Better relationships with SNF, subacute, rehab, PT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# Potential Savings from Effective Purchasing: California Hospitals

- 10 hospitals provided patient-level cost, utilization, and revenue data to Integrated Healthcare Association
- Econometric analysis of variance in implant use and price for orthopedic (N=6055), spine (N=1846) , and cardiac patients (N=1877)
- Secondary analysis of discharge destination and LOS

*American Journal of Managed Care, 2014*

Quantifying Opportunities for Hospital Cost Control: Medical Device Purchasing and Patient Discharge Planning

James C. Robinson, PhD, and Timothy T. Brown, PhD

In the past decade, many hospitals have covered rising costs by merging with erstwhile competitors and demanding ever-higher payment rates from insurers.[1-4] This focus on revenue growth now appears to be of declining value. Private insurers are experimenting with narrow networks and consumer cost-sharing incentives that will channel patient volume away from facilities charging the highest prices.[5,6] CMS has proposed reductions in Medicare hospital payment updates.[7,8] Many hospitals are thus finding they need to shift to a focus on cost reduction to preserve their operating margins.

The changing economic environment presents opport... as well as challenges. Both public and...

ABSTRACT

**Objectives**

To quantify the potential reduction in hospital costs from adoption of best local practices in supply chain management and discharge planning.

**Study Design**

We performed multivariate statistical analyses of the association between total variable cost per procedure and medical device price and length of stay, controlling for patient and hospital characteristics.

**Methods**

# Savings from Purchasing and Discharge Planning, as % of Patient Care Expenditures

**Table 4.** Total Incurred Procedure Costs and Potential Savings for 10 Hospitals From Adoption of Local Best Practices in Supply Chain Management and Discharge Planning

| | Joint Replacement Surgery | Spine Fusion Surgery | Cardiac Rhythm Management |
|---|---|---|---|
| Total incurred costs | $68,510,369 | $33,989,730 | $30,195,611 |
| Total potential savings | $9,925,039 | $6,403,655 | $8,794,178 |
| Savings as % of costs | 14.5% | 18.8% | 29.1% |
| Number of patients | 6055 | 1846 | 1877 |

# What are the Potential Inefficiencies of Hospital-Physician Integration?

If poorly executed, physician-hospital consolidation can…

- Move care to high-cost HOPD rather than low-cost physician-owned settings
- Create higher prices than in competitive markets
- Create complex, slow-moving, bureaucratic organizations



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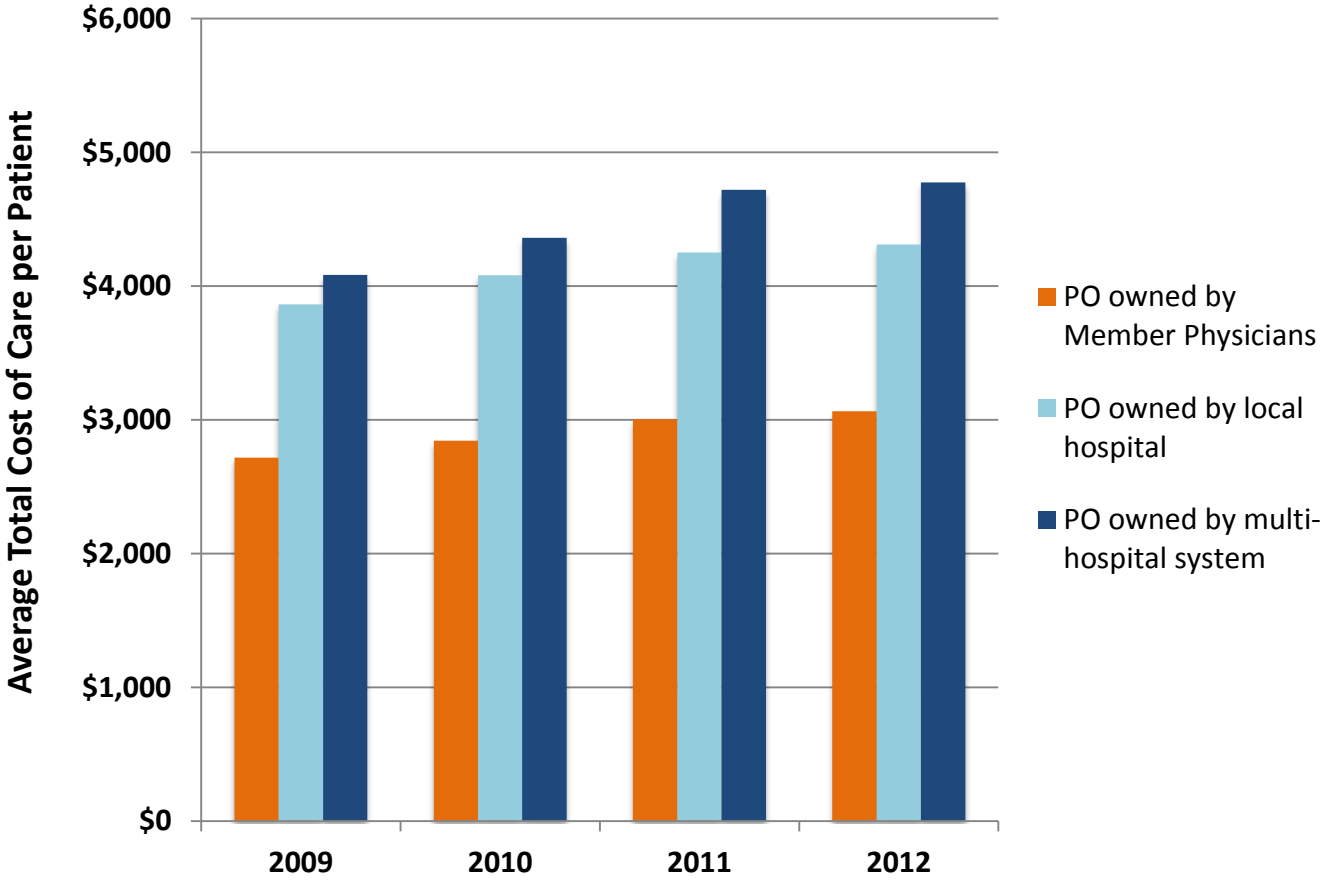
# Price Per Inpatient Procedure: Commercially Insured Patients

| | Angioplasty with Stent | Knee Replacement | Pacemaker Insertion | Lumbar Spine Fusion |
|---|---|---|---|---|
| Concentrated Markets | $30,610 | $24,920 | $23,354 | $48,868 |
| Competitive Markets | $19, 801 | $18,505 | $16,548 | $39,318 |
| % difference after controls for other factors | 53% | 32% | 33% | 30% |

JC Robinson. Hospital Market Concentration, Pricing, and Profitability In Orthopedic Surgery and Interventional Cardiology. Am J Managed Care 2011; 17(6):e241-e248.

# Total Cost of Care per Patient in Physician Organizations in California




JC Robinson, K Miller. Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California. JAMA 2014; 312(16):1663-69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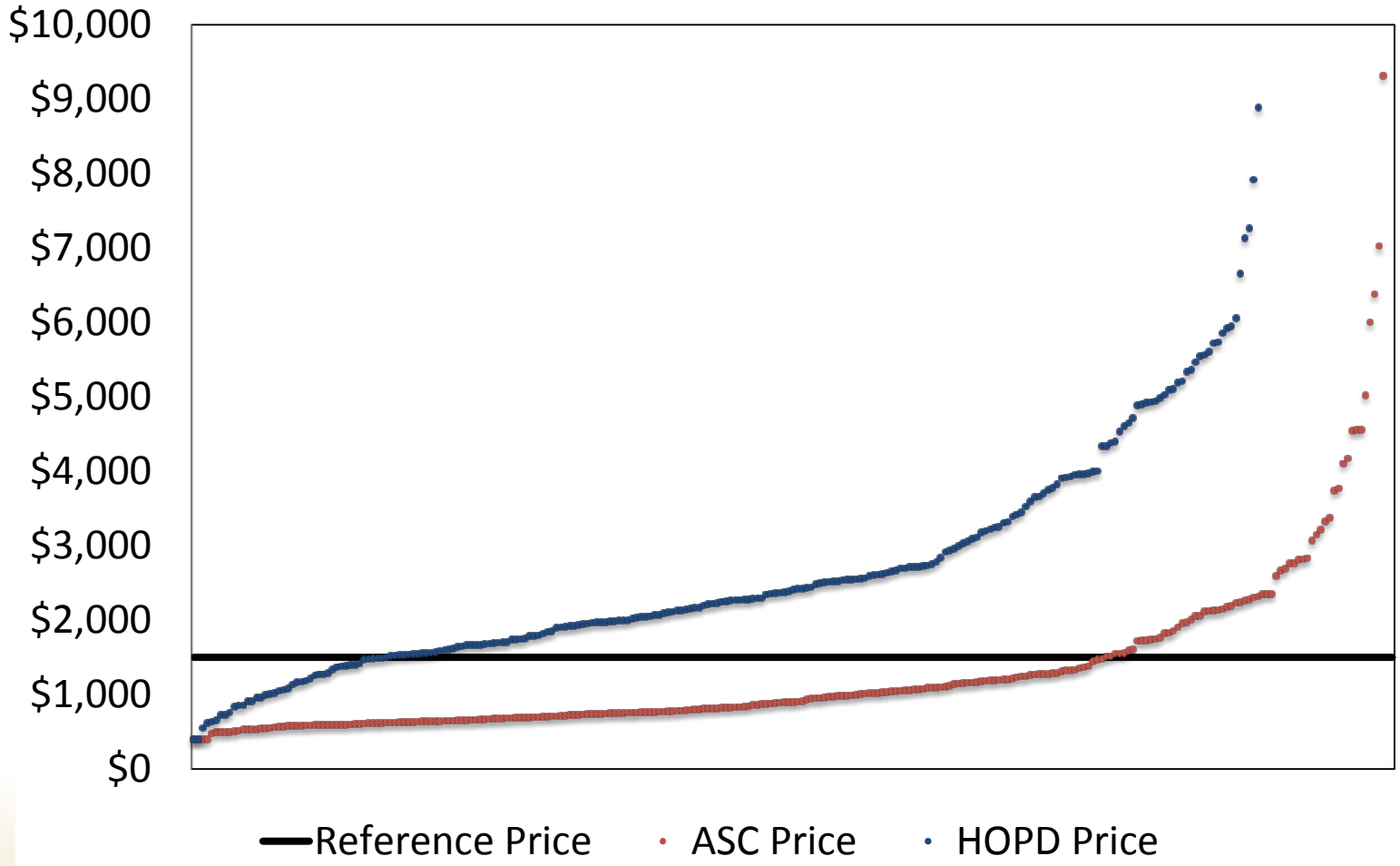
# Colonoscopy Prices Hospital-based (HOPD) and Free-standing (ASC) Clinics




JC Robinson et al. Association of Reference Pricing for Colonoscopy with Consumer Choices, Insurer Spending, and Procedural Complications. JAMA Internal Medicine 2015; doi:10.1001/jamainternmed.2015.4588

# Implications for IPAs

- The death of small independent physician practice has been predicted many times, but this time things are serious, as young physicians pick employment. To sustain their value, IPAs need to:
  - Take advantage of independence from hospitals to incur fewer and less expensive admissions and ambulatory procedures
  - Consider building or aligning with clinic (employment) models to give choices to physicians and patients
  - Improve coordination of referrals, tests, and treatments outside of ownership (vertically integrated) model
  - Consolidate into larger practices to be able to use more physician extenders and part-time physicians
  - Re-engineer processes at the practice level to improve patient satisfaction and retention (see below)

# Evolution of Insurer Strategies

**Benefit design: Increased cost sharing, transparency**
**Network design: HMO to PPO, Narrow Networks**

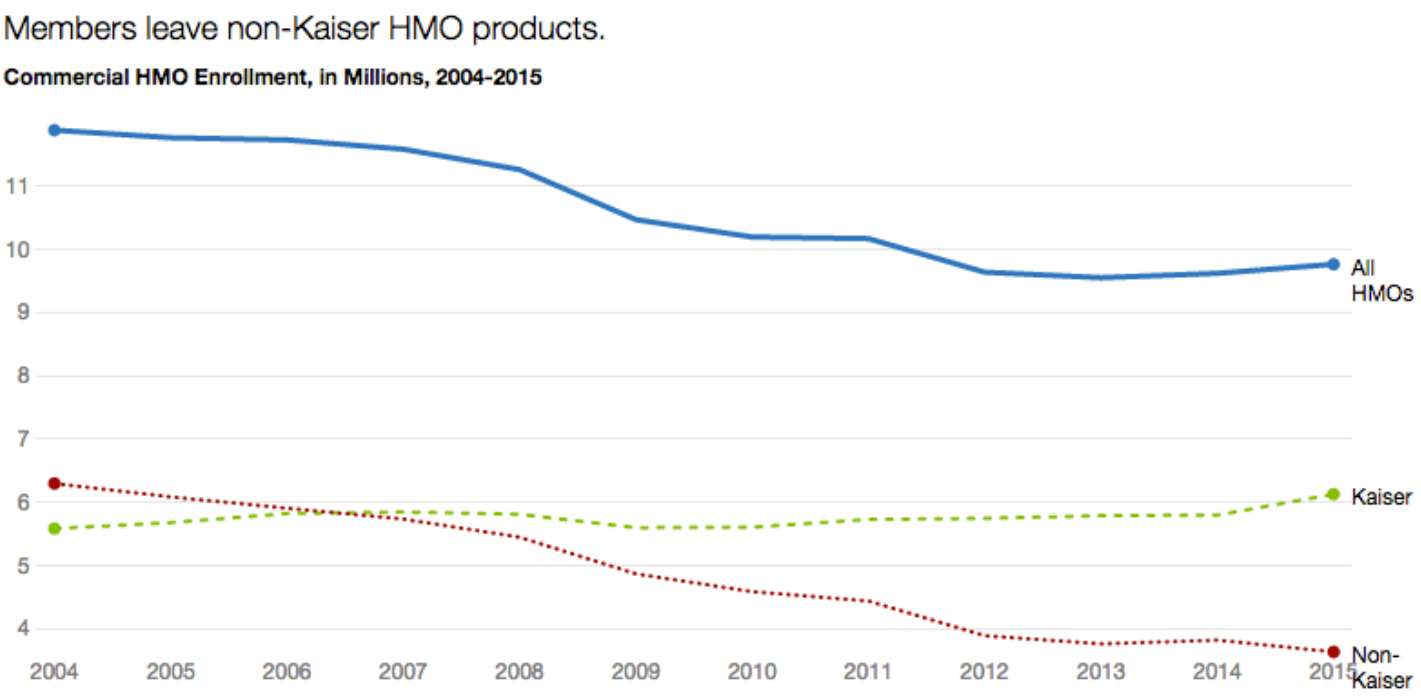

*Mix and match:*

- From HMO to PPO
- High deductible health plans
- Narrow provider networks
- Reference pricing
- Price and quality transparency
- Decision support tools

# Erosion of Commercial (non-Kaiser) HMO

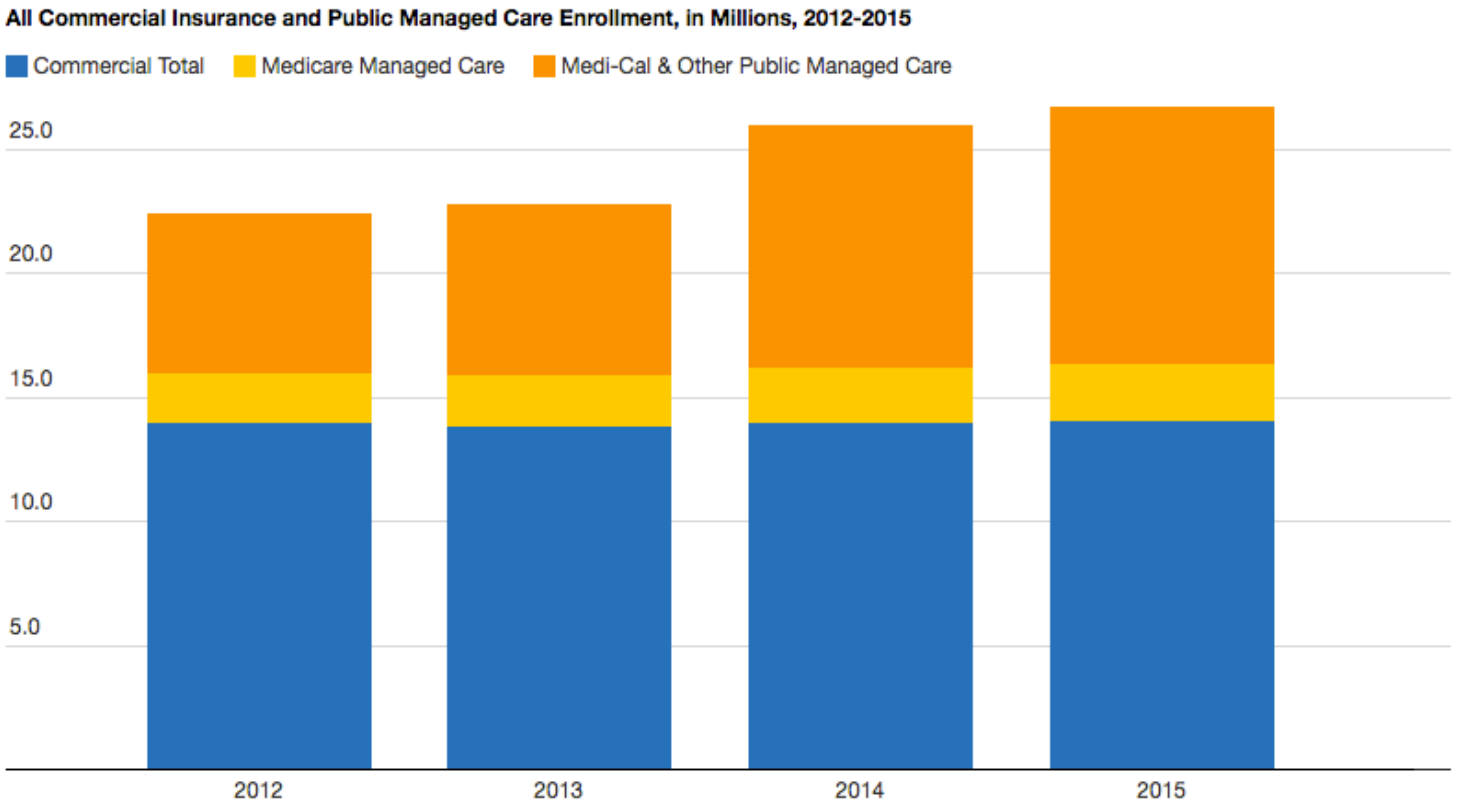
- Employers increasingly are shifting from HMO to PPO coverage in CA and throughout the nation
  - PPO permits higher deductibles and hence lower premiums
  - PPO easier to use with self-insured (ASO) clients who want to manage payments on FFS basis
  - PPO plans have copied many of the cost-reducing innovations from HMOs (UM, DM, referral management, narrow hospital networks)
  - PPO are experimenting with care coordination and innovative payment methods (ACO)
- Frankly, many HMOs have ceased innovating

# Erosion of the Commercial HMO




http://www.chcf.org/publications/2016/11/hmo-enrollment-california

# HMO Enrollment Growth in MediCal and Medicare Advantage

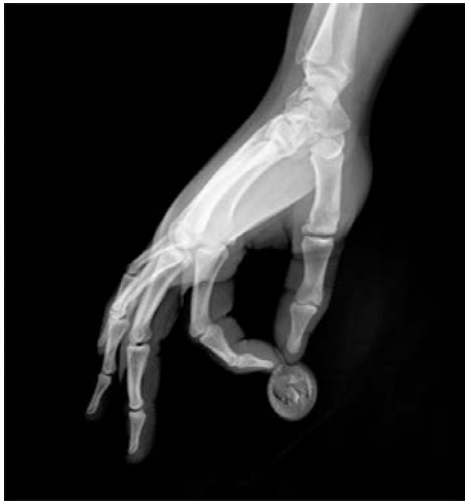



*Note: ASO provided to self-insured employers not shown.*

http://www.chcf.org/publications/2016/11/hmo-enrollment-california

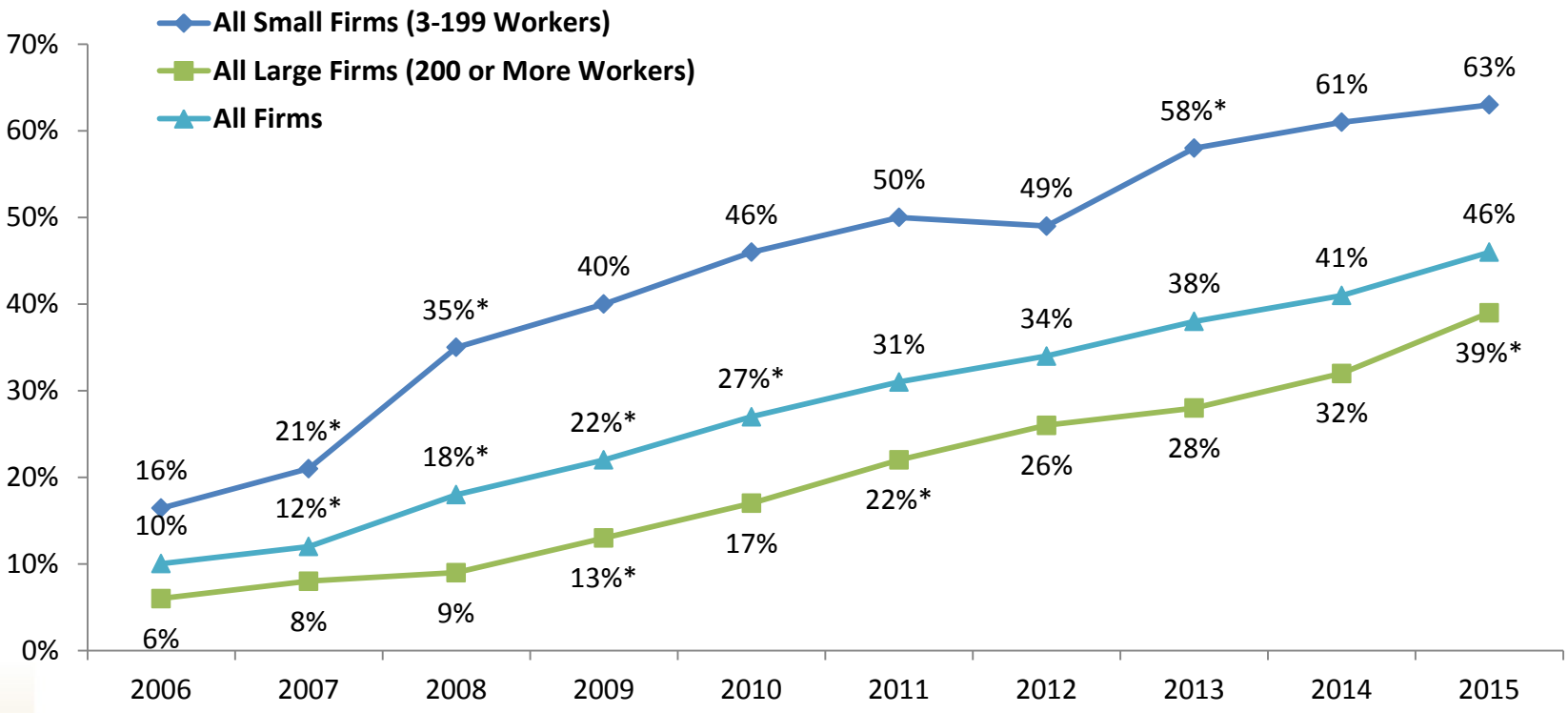
# Shifting Cost to the Patient

- As part of the shift to PPO, employers and insurers are increasing consumer cost sharing obligations
- High annual deductibles
- Coinsurance (%) replacing copayments ($)
- Narrow provider networks
- Reference pricing



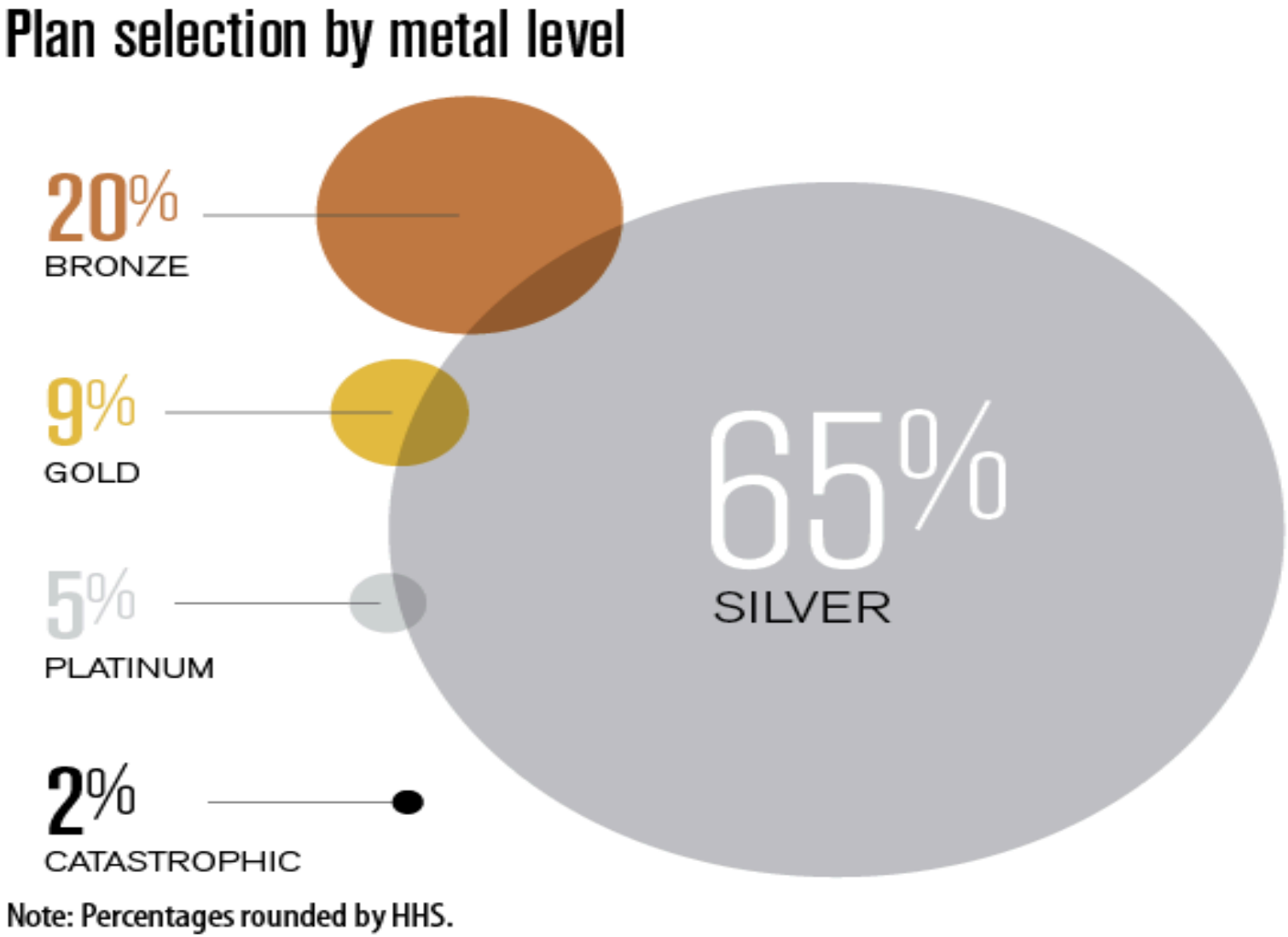
# Employers Move towards High Deductibles

## Require Patient to Pay Initial $1000- $5000 in Costs Incurred




**Percentage of Covered Workers Enrolled in a Plan with a Deductible of $1,000 or More for Single Coverage**
**Source: Kaiser Family Foundation / HRET 2015 Employer Survey**

# Consumers Favor High-Deductible Silver and Bronze Plans in ACA Insurance Exchanges

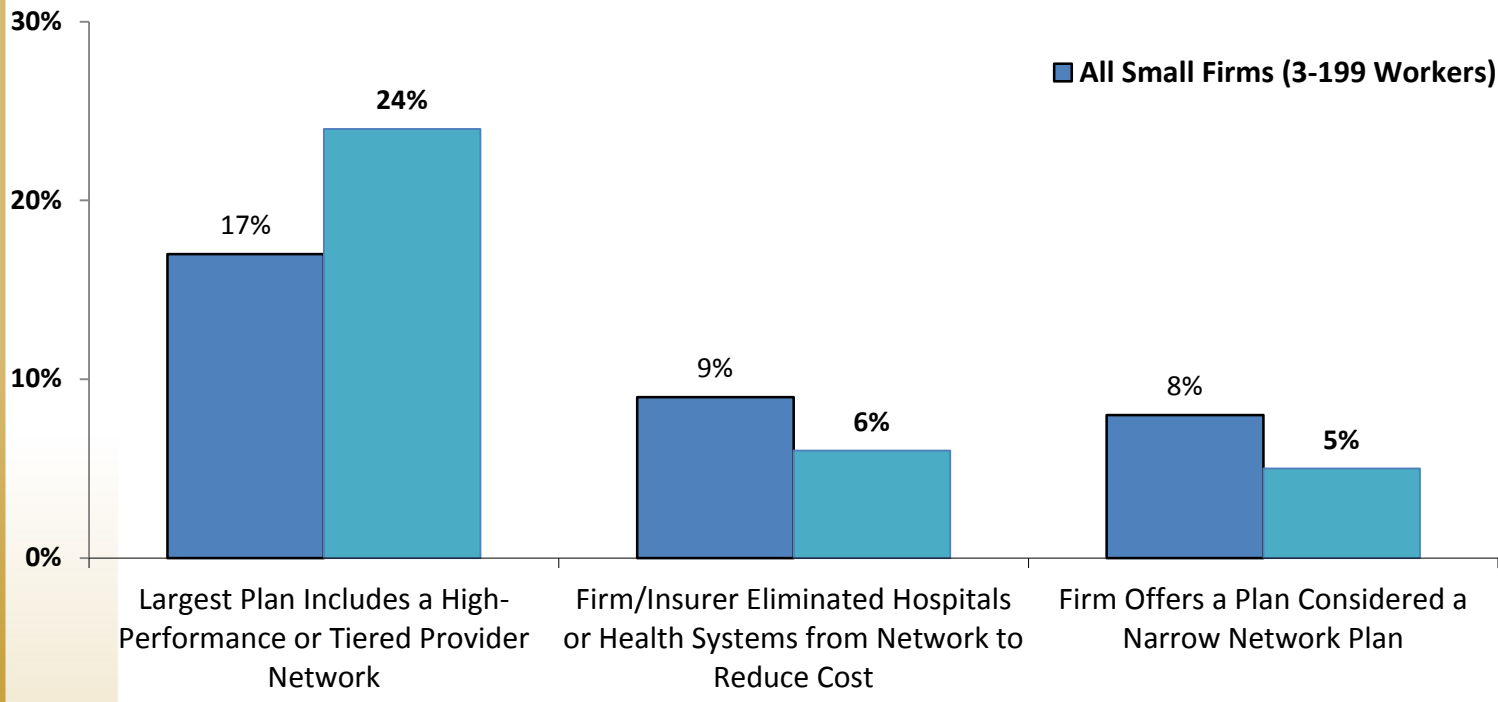


# What is a Bronze or Silver Plan?

| Service | Cost Sharing (Bronze) | Cost Sharing (Silver) |
|---|---|---|
| Deductible | $5,000 | $2,000 |
| PCP Office Visit | $60 (3 per year) | $45 |
| SCP Office Visit | $70 | $65 |
| Urgent Care Visit | $120 | $90 |
| ER Visit | $300 | $250 |
| Lab Test | 30% | $45 |
| X-ray | 30% | $65 |
| Generic Drug | $25 | $25 |
| Brand Drug | $50 | $50 |
| Max OOP: Individual | $6,350 | $6,350 |
| Max OOP: Family | $12,700 | $12,700 |

Source: Covered California *Plan Options Participant Guide*

# Narrow Hospital Networks in Employment-Based Insurance




Source: Kaiser Family Foundation/HRET 2015 Employer Survey

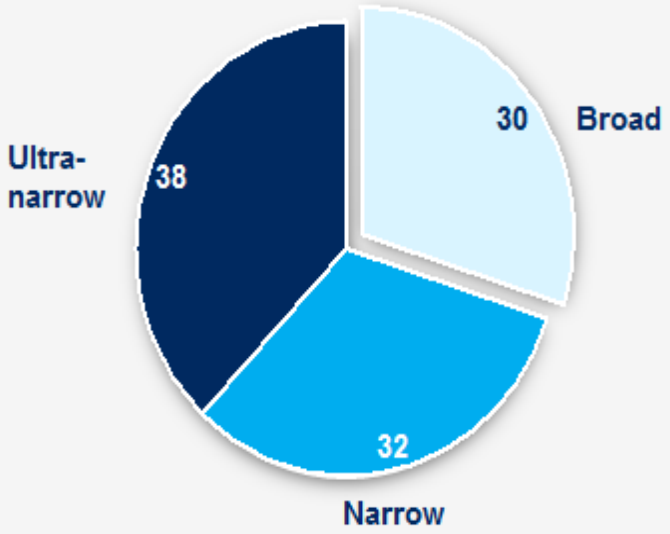
# Narrow Hospital Networks in ACA Insurance Exchanges

EXHIBIT 1

## 70 percent of hospital networks on exchanges are narrow or ultra-narrow

**Distribution of networks by network breadth[1]**

2014 individual exchange – Percent of analyzed silver networks (n = 120[2])




1 Broad networks: less than 30% of largest 20 hospitals by number of beds are not participating, Narrow networks: 30-69% of largest 20 hospitals are not participating, Ultra-narrow networks: at least 70% of largest 20 hospitals are not participating

2 Networks offered in silver in Atlanta, Bridgeport, Dallas, Nashville, Houston, Salt Lake City, Miami, Tampa, Louisville, Indianapolis, St. Louis, Los Angeles, San Jose, Pittsburgh, Denver, Philadelphia, Seattle, Chicago, Washington D.C., and Portland, ME

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly availablerate filings and carrier information; AHA database

*Data as of 11.15.2013*

McKinsey & Company

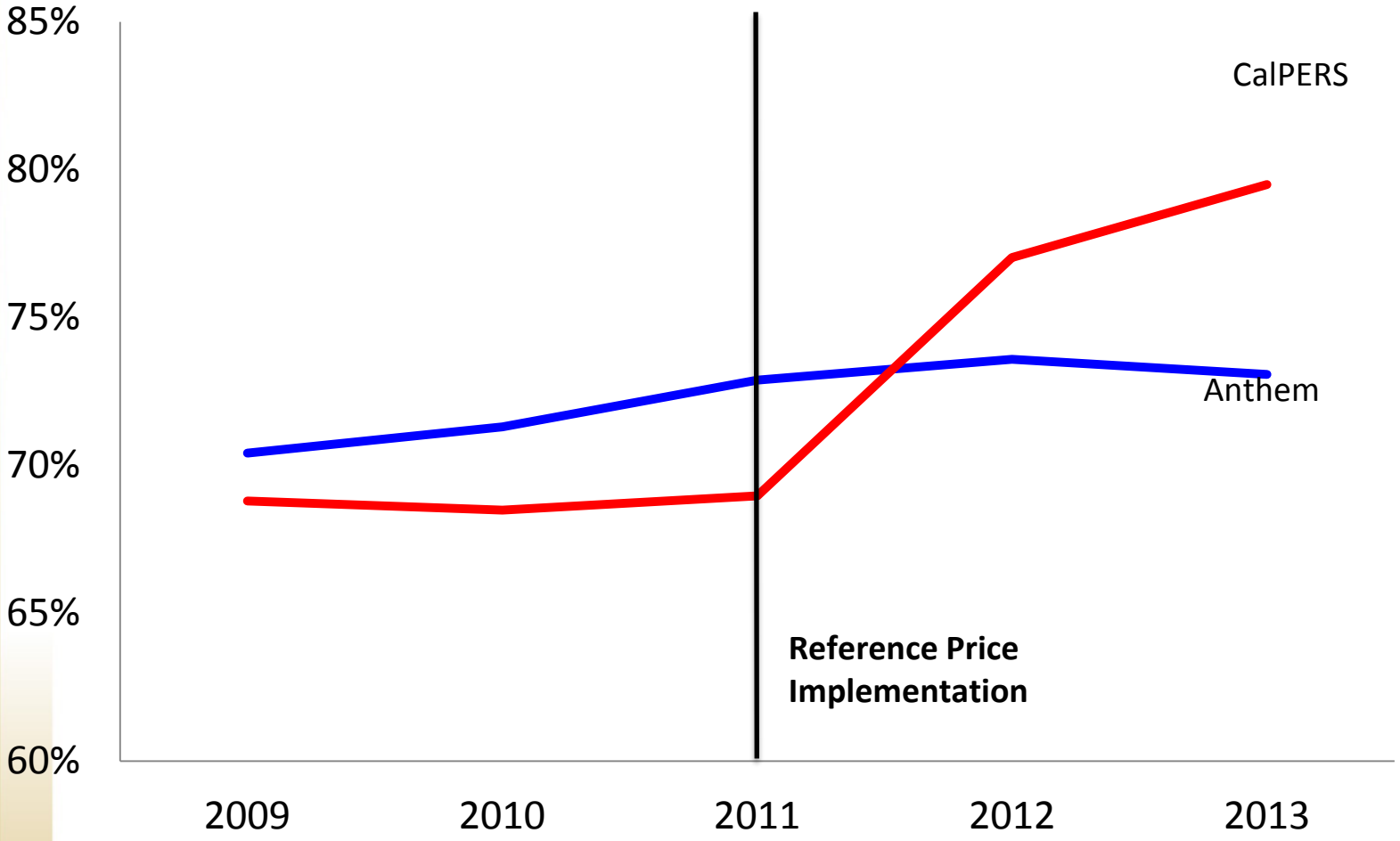
# Reference Pricing

- Sponsor establishes a ***maximum contribution*** (reference price) it will make towards paying for a particular service or product
  - This limit is set at some point along the observed price range (e.g., 60$^{th}$ percentile)
- Patient must ***pay the full difference*** between this limit and the actual price charged by the provider
  - Patient payment is not limited by OOP max
  - Provider price is the negotiated “allowed charge” not the arbitrary list price
  - Patient has good coverage for low priced options but ***full responsibility for choice***

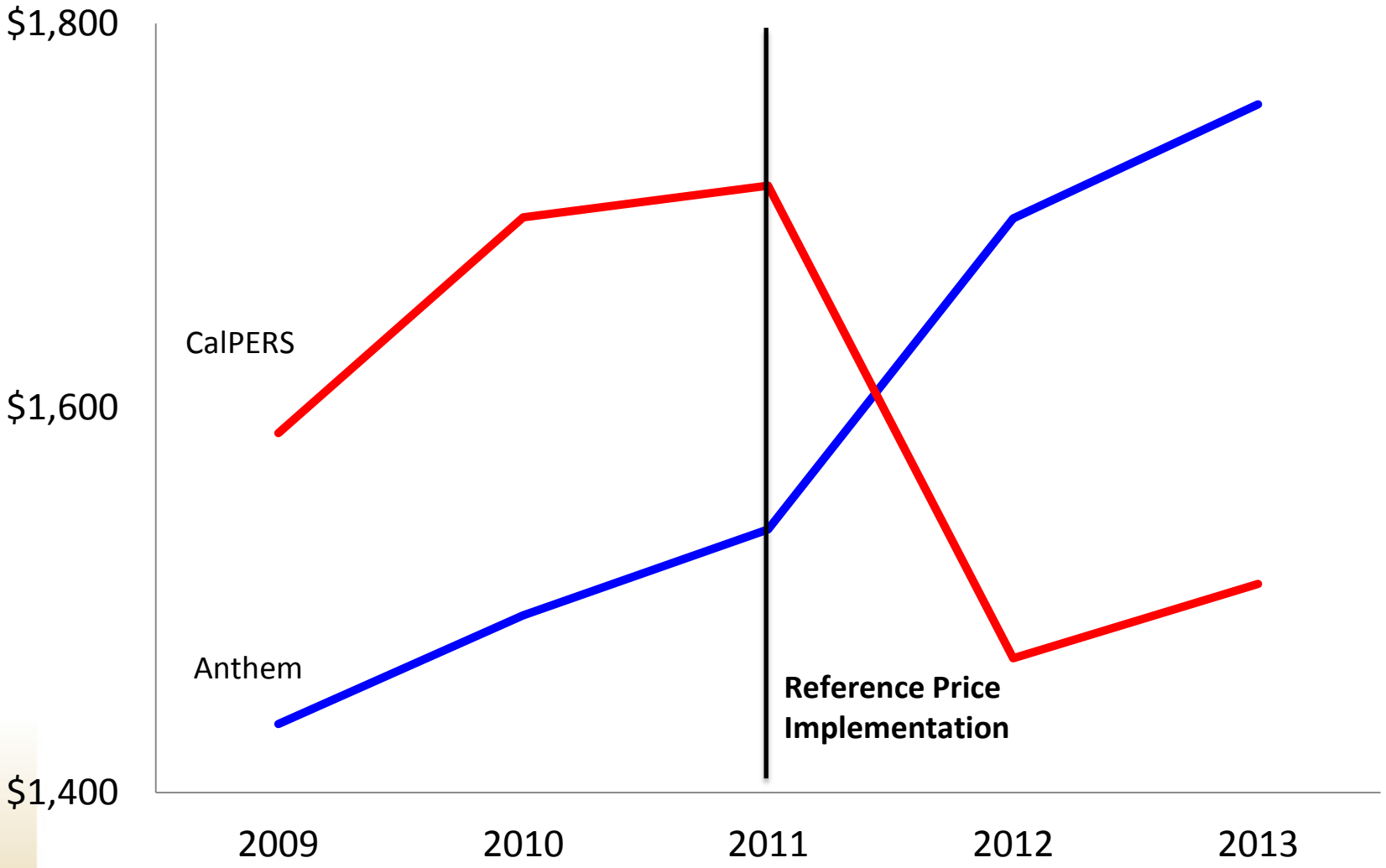
# Example: Colonoscopy

- In 2011 PERS expanded reference pricing to ambulatory procedures, with intent of convincing beneficiaries to select lower-price ambulatory surgery centers (ASC) over hospital outpatient departments (HOPD)
- Reference price was set for HOPD at average price for ASC

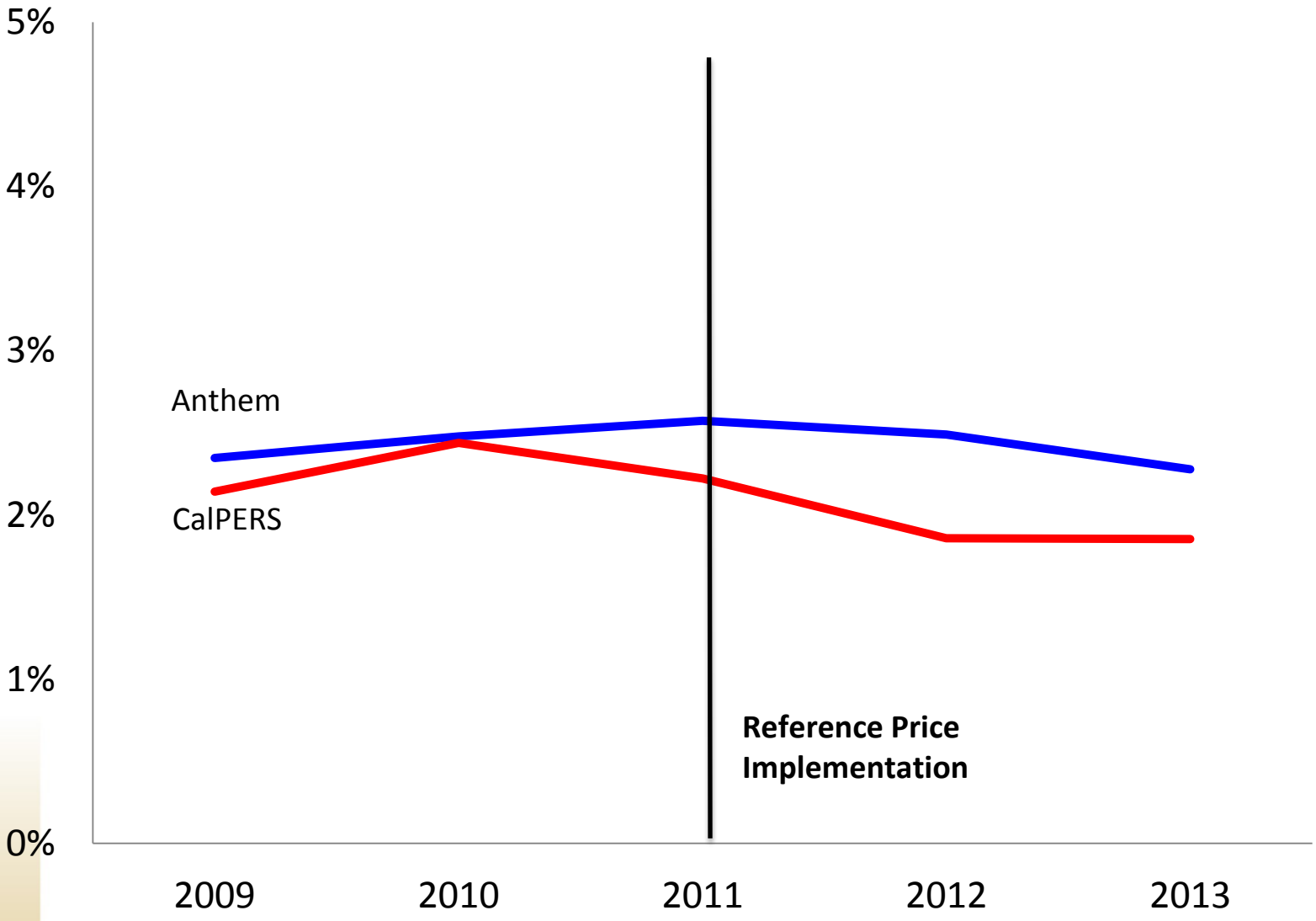
# Colonoscopy Patients Choosing ASC over HOPD before and after Implementation of Reference Pricing



# Price for Colonoscopy Before and After Implementation of Reference Pricing



# Procedural Complications Before and After Reference Pricing Implementation



# Expansion of Reference Pricing

- CalPERS is expanding reference pricing (January 2018) to broader set of ambulatory procedures, to encourage use of physician-owned and freestanding clinics, and discourage use of HOPD
  - Infused chemotherapy and biologics
  - Sigmoidoscopy
  - Upper GI endoscopy
  - Laparoscopic gall bladder removal
  - Tonsillectomy
  - Lithotripsy
  - Septoplasty
  - Hernia repair
  - Etc.

# Price Variation for Ambulatory Procedures, between Hospital-based and Freestanding Physician and Surgical Facilities

**Reference Pricing for Twelve Procedures Compared to Costs for Ambulatory Surgery Centers and Outpatient Hospital Facilities**

| | Upper GI Endoscopy with Biopsy | Laparoscopic Gall Bladder Removal | Upper GI Endoscopy | Esophag-oscopy | Sigmoid-oscopy | Hysteroscopy Uterine Tissue Sample (with Biopsy, with | Nasal/Sinus - Submucous Resection Inferior Turbinate | Tonsillectomy and/or Adenoidectomy, Under Age 12 | Nasal/Sinus - Corrective Surgery - Septoplasty | Lithotripsy - Fragmenting of Kidney Stones | Hernia Inguinal Repair (Age 5+, Non-Laparoscopic) | Repair of Laparoscopic Inguinal Hernia |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ambulatory Surgery Center** | | | | | | | | | | | | |
| Highest Cost | $5,846 | $15,586 | $4,131 | $4,247 | $3,766 | $7,277 | $7,623 | $7,638 | $12,069 | $14,267 | $10,491 | $13,557 |
| Lowest Cost | $721 | $2,661 | $530 | $1,079 | $403 | $1,398 | $1,564 | $1,550 | $2,123 | $3,916 | $2,311 | $1,942 |
| **Outpatient Hospital Facility** | | | | | | | | | | | | |
| Highest Cost | $18,589 | $78,822 | $9,652 | $9,030 | $9,907 | $60,818 | $22,695 | $20,990 | $22,014 | $25,759 | $20,129 | $43,612 |
| Lowest Cost | $786 | $3,082 | $703 | $1,786 | $449 | $1,601 | $4,591 | $1,934 | $4,950 | $3,734 | $2,152 | $3,924 |
| **Recommended Reference Price** | $2,000 | $5,000 | $1,500 | $2,000 | $1,000 | $3,500 | $3,000 | $3,000 | $3,500 | $7,000 | $4,000 | $5,500 |
| CalPERS Annual Projected Savings Per Procedure | $608,102 | $560,857 | $109,775 | $21,137 | $24,683 | $112,468 | $108,900 | $94,505 | $125,637 | $96,731 | $99,711 | $76,737 |
| **TOTAL ANNUAL PROJECTED SAVINGS** | | | | | | | | | | | | $2,039,242 |
| Assumes 10% increase in ASC use | | | | | | | | | | | | |

CalPERS. Pension and Health Benefits Committee.
Health Benefit Design Proposals for 2018. April 18, 2017.

# Implications for IPAs

- PPOs traditionally have avoided IPAs, contracting directly with MDs and not delegating UM, DM. If IPAs are to prove their value, they must
  - Improve process and outcome of their UM and DM programs
  - Consider following their commercial patients into PPO products, via the PPO ACOs
  - Consider alternatives to capitation (FFS for visits, monthly PMPM for care management, annual bonus for quality and cost management)
  - Prove their value as the core of narrow network products, both HMO and PPO
  - Continue to grow in Medi-Cal and MAPD
  - Consider participating in Medicare ACO

# Patients are Becoming Consumers

- Customers (patients) are becoming more informed and demanding
  - Easy access to regular PCP
  - Online appointments, prescriptions, email with doctor
  - Uncomplicated referral to specialist and facility
  - They want more service for their increased cost sharing

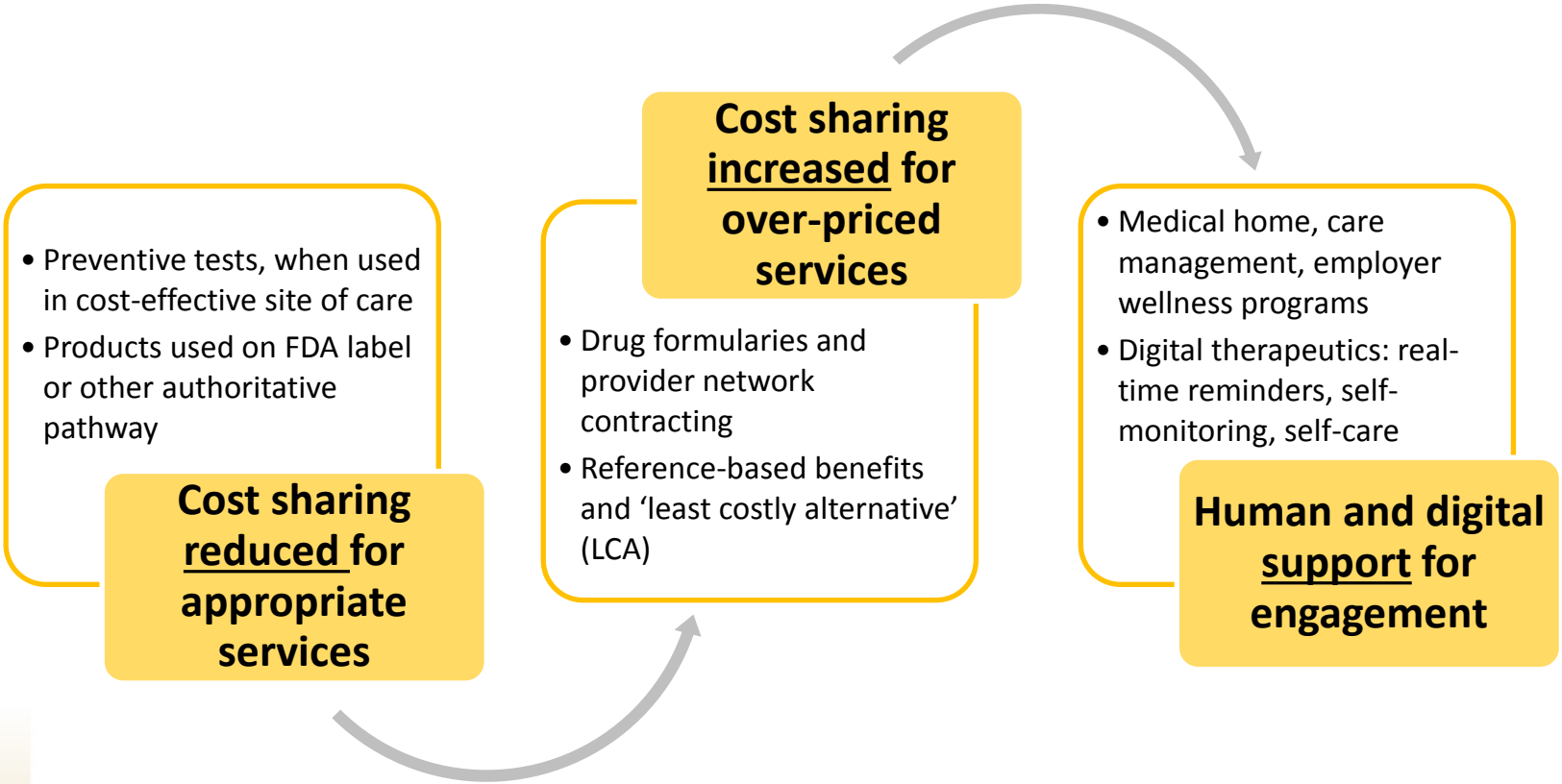
# Patient and Consumer Engagement

**Over-use of health care:** Demand for unnecessary treatments due to excessive insurance and mistaken belief that more is always better

***Some patients are very engaged, educated, and demanding, while others lack the information and incentives to demand high-value health care***

**Under-use of health care:** Lack of engagement and adherence, even to effective therapies, due to punitively high cost sharing and cultural barriers

# Where are Insurers Going to Promote Engagement?



# Price and Quality Transparency

| Company and Product | Information Offered | Platform |
|---|---|---|
| **Castlight Health** | • Price transparency – flagship firm<br>• Plan benefit information for consumers<br>• Employer analytics | • Varied: web tools, delivered insights, mobile tools for employees |
| **Aetna iTriage** | • Price comparison information from Healthcare Bluebook<br>• Healthcare services information<br>• Adding new services in future | • Mobile integrated data platform, including an app |
| **UnitedHealthcare MyEasyBook** | • Online health care shopping tool for consumers with high-deductible plans | • Integrated in with members' claims, transparency tools, and in-network providers |
| **Guroo** | • Cost information for over 70 common health conditions and services based on claims data from four major insurers | • Consumer-facing website<br>• Has received Medicare data as a "qualified entity" |
| **Health in Reach** | • Comparison of licensed providers, including doctors and dentists<br>• Discounts and deals<br>• Online appointment system | • Consumer-facing website<br>• Providers can sign up to create a profile |

# Information Coupled with Active Outreach

| Company and Product | AIM Specialty Health<br>Specialty Care Shopper Program |
|---|---|
| **History** | • Began as American Imaging Management, a radiology benefit management company<br>• Acquired by WellPoint in 2007<br>• Current services expand beyond radiology |
| **Approach** | • Through the Specialty Care Shopper Program, an AIM specialist proactively contacts a health plan member once a service (e.g. an MRI or CT) has been approved if there is a high-quality, lower-cost site-of-care option available within their local community<br>• If the member decides to accept the recommendation, AIM assists the member in scheduling the appointment |
| **Rationale** | • The cost of a given procedure can vary widely across providers and care delivery settings within the same geographic area<br>• Giving patients information may help them select lower-cost options |
| **Results** | • Since its implementation in one market in 2011, AIM has redirected more than 4,900 cases, at an average cost savings of $950 per case<br>• A study published in Health Affairs found that for patients needing MRIs, the AIM program resulted in a $220 cost reduction (18.7%) per test and a decrease in use of hospital-based facilities from 53 percent in 2010 to 45 percent in 2012 |

Sources: http://www.aimspecialtyhealth.com/solutions/management-solutions/member-management;
Sze-jung Wu, Gosia Sylwestrzak, Christiane Shah and Andrea DeVries, “Price Transparency For MRIs Increased Use Of Less Costly Providers And Triggered Provider Competition,” *Health Affairs*, 33, no.8 (2014):1391-1398

# Decision Support Tools for Patients

| Company | Optum (UnitedHealth Group) | |
|---|---|---|
| **Product** | **Emergency Room Decision Support** | **Treatment Decision Support** |
| **Goal** | • Engage health plan members after each emergency room visit to address factors that drive inappropriate ER use | • Connect members with the right treatment, right provider, right medication, and right lifestyle |
| **Approach** | • Identifies and engages individuals after each emergency room visit – up to five times during the course of a year<br>• Leverages both "live" nurses and automated voice call technology to engage consumers<br>• Refers to case and disease management programs and behavioral health services<br>• Connects individuals with primary care providers (including appointment scheduling) | • Connects members with specially trained nurse "coaches" who address a consumer's immediate symptom in addition to issues that impact their quality of life and care<br>  • Right treatment — guidance on when and where to seek care<br>  • Right provider — scheduling appointments with high-quality network providers<br>  • Right medication — coaching on lower cost options, drug interactions and appropriate use<br>  • Right lifestyle — referring to wellness and behavioral health services |
| **Results** | • Individuals who were engaged by ER Decision Support had a decrease in avoidable ER visits, while individuals who did not participate had an increase in avoidable visits (2007-2008) | • 2-to-1 average return on investment<br>• 70 percent of callers with ER pre-intent avoid the visit after a Optum NurseLine call<br>• 8.8 hours reduced absenteeism per employee/per event |

Sources: https://www.optum.com/health-plans/clinical-management/member-support/clinical-care-management/navigate-care-options/emergency-room-decision-support.html; https://www.optum.com/health-plans/clinical-management/member-support/clinical-care-management/navigate-care-options/treatment-decision-support.html

# Implications for IPAs

- Advantage of IPA and small practices should be intimacy, access, and customer focus
  - Better scheduling and PCP access
  - Better management and attention to price for specialty referrals
  - Better follow-up after procedures and admissions
  - Greater attention to lifestyle (e.g., obesity) and behavioral (e.g., opiate addiction) factors
- Measurement, reward, and continuous improvement for patient satisfaction and retention

# The Health Care System Requires More from Everyone

- Consumers: cost sharing, engagement, and informed choice
- Health plans: benefit and network designs to align incentives
- Physicians: primary care access, referral management, customer service
- Physician organizations: practice redesign, quality & efficiency, leadership

# Are you ready?


***"The gentleman at the other register would like to cover your co-pay."***

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